Calendar No. 691

100TH CONGRESS *1st Session*	SENATE	REPORT 100-360

MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1988

MAY 25 (legislative day, MAY 18), 1988.—Ordered to be printed

---

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany S. 1265]

The Committee on Labor and Human Resources, to which was referred the bill S. 1265, to amend the Public Health Service Act and the Fair Labor Standards Act of 1938 to provide minimum health benefits for all workers in the United States, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

I. Summary of the bill 1
II. Committee amendment 3
III. History of the legislation 18
IV. Background and need for legislation 20
V. Tabulation of votes in committee 26
VI. Cost estimate 27
VII. Regulatory impact statement 30
VIII. Section-by-section analysis 31
IX. Committee views 39
X. Additional views 64
XI. Minority views 67
XII. Changes in existing law 88

I. SUMMARY OF THE BILL

S. 1265 amends the Public Health Service Act, the Fair Labor Standards Act, and the Employee Retirement Income Security Act

85-526

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

5543-9

(ERISA) to require that employers enroll their full-time employees (those working a least 17.5 hours per week) in a minimum health benefit plan that covers specific basic health services and provides protection against catastrophic out-of-pocket expenses. Dependents of employees would also have to be covered by the employer's plan, unless they were insured by other employment-based plans.

The services that an employer's plan would be required to cover would include medically necessary inpatient and out-patient hospital and physician care, diagnostic and screening tests, prenatal and well-baby care and limited inpatient and out-patient mental health services. Plans would have to include a catastrophic cap (stop-loss) on out-of-pocket costs for covered services of no more than $3,000.

A plan could not exclude coverage for pre-existing health conditions. S. 1265 allows the costs of the minimum benefit package to be shared by the employer and the employee. In general, the employer would be required to pay 80 percent of the premium; for workers earning under $4.19 an hour (125 percent of the minimum wage), employers would be required to pay the full premium. Deductibles paid by the employee could not exceed $250 per individual and $500 per family in the first year (except for pre-natal and well-baby care, for which no cost sharing could be imposed).

To assure employers adequate flexibility to respond to the needs of their work force and to minimize interference with existing employment-based health insurance plans, the legislation establishes an actuarial equivalency test for compliance with the minimum standards. Employers covering the basic services required by the statute could adjust co-payments, deductibles, stop-loss levels and premium shares as long as the actuarial value of the plan they offered was equal to or better than the minimum plan.

The legislation requires provision of health insurance for employees of almost all businesses. However, employers with less than ten employees who have been in business for less than two years would be required to offer only catastrophic coverage to their employees. Coverage for employees of businesses with five or fewer workers would be phased in over a five year period.

S. 1265 would create a system of regional insurers to provide community-rated, lower cost insurance to small businesses (defined as 25 employees or less). Regional insurers would provide a selection of indemnity and managed care health insurance plans that meet the standards of the minimum health benefit package. Each insurer would be required to offer at least a minimum health benefit plan and a comprehensive plan.

An employer that failed to provide a minimum health benefit plan would be subject to civil penalties. Individuals could also sue in Federal Court for injunctive relief, and for damages. State and local governments that failed to provide insurance would be subject to the loss of their eligibility for grants, contracts, loans or loan guarantees under the Public Health Service Act.

In addition, S. 1265 amends ERISA to pre-empt State regulation of the content of health insurance. States would continue to have responsibility for regulating the financial stability of health insurance companies.

II. Committee Amendment

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the "Minimum Health Benefits for All Workers Act of 1988".

(b) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Sec. 101. Minimum health benefits for employees and their families.

TITLE II—AMENDMENTS TO FAIR LABOR STANDARDS ACT OF 1938 AND EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 201. Minimum health benefits for employees and their families.
Sec. 202. Preemption under Employee Retirement Income Security Act of 1974.

TITLE III—REQUIREMENTS FOR HEALTH BENEFIT PLANS FOR EMPLOYEES AND THEIR FAMILIES

Subtitle A—Requirement and Definitions

Sec. 301. Employer requirement to enroll employees in health benefit plans.
Sec. 302. Coverage of family members.
Sec. 303. Definitions.

Subtitle B—Requirements for Health Benefit Plans

Sec. 311. General requirements; permitting actuarially equivalent plans.
Sec. 312. Requirements relating to covered items and services.
Sec. 313. Requirements relating to timing of coverage and prohibition of preexisting condition limitations.
Sec. 314. Requirements relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses.

Subtitle C—Certification of Regional Insurers

Sec. 321. Designation of health insurance regions.
Sec. 322. Periodic certification of regional insurers.
Sec. 323. Requirements of regional insurers.
Sec. 324. Miscellaneous provisions.

Subtitle D—Regulations and Enforcement

Sec. 331. Regulations.
Sec. 332. Enforcement.

TITLE IV—EFFECTIVE DATE

Sec. 401. Effective date.
Sec. 402. Policy respecting additional benefits.

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 101. MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) Requirement.—The Public Health Service Act is amended—

(1) by redesignating title XXIII (42 U.S.C. 300cc et seq.) as title XXIV; and

(2) by inserting after title XXII (42 U.S.C. 300bb-1 et seq.) the following new title:

"TITLE XXIII—MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"SEC. 2301. HEALTH BENEFITS.

"(a) In General.—Each employer shall, in accordance with title III of the Minimum Health Benefits for All Workers Act of 1988, enroll each of its employees and their families in a health benefit plan.

"(b) Enforcement.—

"(1) Ineligibility for assistance.—An employer that is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision and that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall not be eligible to receive a grant, contract, loan, or loan guarantee under this Act.

"(2) General enforcement provisions.—Any employer that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Minimum Health Benefits for All Workers Act of 1988.

"(c) Definitions.—The terms used in this section have the meanings prescribed for the terms by section 303 of such Act.".

(b) Conforming Amendments.—

(1) Sections 2301 through 2316 of the Public Health Service Act (42 U.S.C. 300cc through 300cc-15) are redesignated as sections 2401 through 2416, respectively.

(2)(A) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are each amended by striking out "2301" and inserting in lieu thereof "2401".

(B) Section 305(h) of such Act (42 U.S.C. 242c(h)) is amended by striking out "2313" each place it appears and inserting in lieu thereof "2413".

TITLE II—AMENDMENTS TO FAIR LABOR STANDARDS ACT OF 1938 AND EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

SEC. 201. MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) Health Benefits.—The Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) is amended by adding at the end thereof the following new title:

"TITLE II—MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"SEC. 201. HEALTH BENEFITS.

"(a) In General.—Each employer shall, in accordance with title III of the Minimum Health Benefits for All Workers Act of 1988, enroll each of its employees and their families in a health benefit plan.

"(b) Enforcement.—Any employer that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Minimum Health Benefits for All Workers Act of 1988.

"(c) Definitions.—The terms used in this section have the meanings prescribed for the terms by section 303 of such Act.".

(b) Conforming Amendments.—

(1) The Fair Labor Standards Act of 1938 is amended by striking out the first section and inserting in lieu thereof the following:

"SECTION 1. SHORT TITLE.

"This Act may be cited as the 'Fair Labor Standards Act of 1938'.

"TITLE I—WAGES AND HOURS".

(2) The Fair Labor Standards Act of 1938 is amended by striking out "this Act" each place it occurs and inserting in lieu thereof "this title".

SEC. 202. PREEMPTION UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) In General.—Section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraph:

"(C) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, contracts or policies of insurance issued to or under a health benefit plan under title III of the Minimum Health Benefits for All Workers Act of 1988, except that a State may require an insurer, other than a regional insurer, to provide such evidence of financial stability as the State determines appropriate in order to be allowed to market insurance in the State.".

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 3 of such Act (29 U.S.C. 1002(1)) is amended by adding at the end the following new sentence: "Such terms include a health benefit plan established in accordance with title III of the Minimum Health Benefits for All Workers Act of 1988.".

TITLE III—REQUIREMENTS FOR HEALTH BENEFIT PLANS FOR EMPLOYEES AND THEIR FAMILIES

Subtitle A—Requirement and Definitions

SEC. 301. EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES IN HEALTH BENEFIT PLANS.

(a) IN GENERAL.—This title shall apply to employers required to enroll employees in health benefit plans under section 2301(a) of the Public Health Service Act or under section 201(a) of the Fair Labor Standards Act of 1938.

(b) TYPES OF PLANS PERMITTED.—

(1) IN GENERAL.—Except as required under paragraph (2), a employer may meet the requirements of this title through any health benefit plan.

(2) PROVISION OF HEALTH BENEFIT PLANS THROUGH REGIONAL INSURERS.—

(A) EMPLOYERS REQUIRED TO USE REGIONAL INSURERS.—

(i) EMPLOYERS WITHOUT A HEALTH BENEFIT PLAN.—Except as permitted under subparagraph (B)(ii), each employer, that does not have in effect a health benefit plan on the day before the effective date (as defined in paragraph (3)(A)), shall meet the requirements of this title through any health benefit plan of a regional insurer established under section 323(a).

(ii) SMALL EMPLOYERS CHANGING PLANS.—Each small employer that—

(I) does have in effect a health benefit plan on the day before the effective date, but

(II) changes the insurer through which the plan is offered or changes the plan from a self-insured plan to a plan of an insurer,

shall then meet the requirements of this title through any health benefit plan of a regional insurer under section 323(a).

(B) CONTINUED USE OF REGIONAL INSURERS REQUIRED.—

(i) IN GENERAL.—If an employer meets the requirements of this title through any health benefit plan of a regional insurer under section 323(a), except as permitted under subparagraph (ii), the employer shall continue to meet such requirement through such a plan.

(ii) EXCEPTION FOR CERTAIN LARGE EMPLOYERS.—A large employer (other than an employer that was a large employer on the day before the effective date) that meets the requirements of this title through any health benefit plan of a regional insurer under section 323(a) may elect to meet the requirements of this title other than through a health benefit plan of a regional insurer under section 323(a). If such an election is made and so long as the employer remains a large employer, the employer no longer has the right under subtitle C to meet the requirements of this title through any health benefit plan of a regional insurer.

(C) CERTAIN PLANS.—Notwithstanding paragraphs (A) and (B), an employer may meet the requirements of this title by maintaining or contributing to a plan described in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)). An employer that maintains or contributes to such a plan shall not be required to meet the requirements of this title through any health benefit plan of a regional insurer.

(3) DEFINITIONS.—In paragraph (2):

(A) EFFECTIVE DATE.—The term "effective date" means January 1 of the second year that begins after the date of the enactment of this Act.

(B) LARGE EMPLOYER.—The term "large employer" means an employer that is not a small employer.

(C) SMALL EMPLOYER.—The term "small employer" means, with respect to a calendar year, an employer that employs an average number of employees of less than 25. Section 607(4) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(4)) shall apply in the determination under this subsection of whether an employer is a large or small employer.

SEC. 302. COVERAGE OF FAMILY MEMBERS.

(a) REQUIREMENT.—Except as permitted under subsections (b) and (d)—

(1) enrollment of an employee in a health benefit plan under this title includes enrollment of the employee's family in the plan; and

(2) enrollment of the employee or the employee's family in a health benefits plan may not be waived by the employee.

(b) EXCEPTIONS TO AVOID DUPLICATE FAMILY COVERAGE.—

(1) SPOUSE OR PARENT EMPLOYED.—An employee, at the employee's option, may waive enrollment in a health benefit plan under this title for the spouse or a child of the employee but only for such period as the employee demonstrates that such spouse or child, respectively, is actually covered under a health benefit plan because the spouse or the child's other parent, respectively, is also an employee.

(2) CHILD EMPLOYED.—A child who is employed may waive enrollment in a health benefit plan provided by the child's employer during any period in which the child is covered under a health benefit plan under this title due to the employment of the child's parent.

(c) NONDISCRIMINATION.—An employer may not fail or refuse to hire, or may not discharge or otherwise discriminate against, any individual because the individual has a spouse or child and such employer is required under this title to enroll the spouse or child in a health benefit plan.

(d) MULTIPLE EMPLOYERS.—In the case of an employee who performs 17½ hours of service per week for two employers, the employee may waive enrollment in the health benefit plan of one of the employers.

SEC. 303. DEFINITIONS.

In this title:

(1) CHILD.—The term "child" means an individual who is—

(A) under 18 years of age; or

(B) under 23 years of age and a full-time student.

(2) EMPLOYEE.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term "employee" means, with respect to an employer, an individual who performs 17½ hours of service per week for that employer.

(B) HANDICAPPED WORKERS.—The term "employee" does not include an individual described in section 14(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 214(c)).

(C) CERTAIN EMPLOYERS.—The term "employee" means, with respect to an employer described in section 3(37) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(37)), an individual who performs—

(i) 17½ hours of service per week for the employer; or

(ii) an equivalent amount of service during a 1-, 3-, or 6-month period for the employer, as determined under regulations issued by the Secretary.

(D) TEMPORARY EMPLOYEES.—

(i) IN GENERAL.—The term "employee" does not include a temporary employee.

(ii) TEMPORARY EMPLOYEE.—The term "temporary employee" means an individual employed by a temporary help services firm who is assigned to perform duties for a corporation, partnership, or other entity who is not an employee, except as specified in clause (iv).

(iii) TEMPOARY HELP SERVICES FIRM.—The term "temporary help services firm" means an organization engaged in the business of furnishing temporary employees for a corporation, partnership, or other entity.

(iv) CERTAIN TEMPORARY EMPLOYEES TREATED AS EMPLOYEES.—A temporary employee who is assigned to perform and complete at least 750 hours of service for a temporary help services firm on behalf of one or more corporations, partnerships, or other entities in a period of 6 consecutive months shall be treated as an "employee" under this title.

(3) EMPLOYER.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term "employer" means with respect to a calendar quarter—

(i) an employer that is required to pay the individuals it employs the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206) (or would be required to pay such wage but for the dollar volume standards prescribed in section 3(s) of such Act (29

U.S.C. 203(s)) or the exemptions prescribed in section 13(a) of such Act (29 U.S.C. 213(a))); and

(ii) any State or political subdivision thereof, or any agency or instrumentality thereof.

(B) FAMILY FARMERS.—

(i) PRICE SUPPORT GREATER THAN 70 PERCENT OF PARITY.—The term "employer" shall not include the owner or operator of a family farm unless the level of agricultural prices, or the minimum level of agricultural price support provided by the Secretary of Agriculture for loans and purchases, for the major commodity produced on the farm is equal to or greater than 70 percent of the parity price of the commodity as maintained by the Secretary during the preceding 2 crop years.

(ii) PRICE SUPPORT LESS THAN 70 PERCENT OF PARITY.—Owners and operators of a family farm who do not receive minimum agricultural price support through loans and purchases that is equal to or greater than 70 percent of parity for the major commodity produced on the farm from the Secretary of Agriculture for the preceding crop year shall be included within the definition of the term "employer" only if, based on a national referendum conducted by the Secretary of Agriculture, a majority of the owners and operators vote in favor of mandatory participation in the low-cost regional insurance program provided by this title.

(iii) NO INSURED EMPLOYEES.—Owners and operators of family farms with no employees required to be insured under this title, may be included in the definition of "employee" under this title if, based on a national referendum conducted by the Secretary of Agriculture, a majority of farmers in the commodity group vote in favor of mandatory participation in the low-cost regional insurance program provided by this title.

(iv) DEFINITION OF FAMILY FARM.—As used in this subparagraph, the term "family farm" means a farm with respect to which—

(I) the operator or the family of the operator, or both (or, if the operator is a cooperative, corporation, partnership, or joint operation, the members, stockholders, partners, or joint operators, respectively) devote a substantial amount of time daily to the management or operation of the farm;

(II) a majority of the hours of labor required annually for the (farm and nonfarm) enterprise of the farm is provided by the operator or the family of the operator, or both (or, if the operator is a cooperative, corporation, partnership, or joint operation, by the members, stockholders, partners, or joint operators, respectively, and the families of such individuals), and

(III) the value of the gross annual sales of agricultural commodities produced on the farm is not more than $750,000.

(C) DOMESTIC SERVICE EMPLOYERS.—The term "employer" shall not include an employer that is required to pay the individuals it employs the minimum wage prescribed by section 6(f) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(f)) (or would be required to pay the minimum wage prescribed by section 6 of such Act but for section 13(a)(15) of such Act (29 U.S.C. 213(a)(15)).

(D) OWNER-OPERATORS.—The term "employer" shall include an owner-operator of a business if the owner-operator has one or more employees who are required to be covered by a health benefit plan.

(E) CONSULTANTS AND CONTRACTORS.—The term "employer" shall include an individual who is a consultant or contractor of an employer if the Secretary determines that the consulting arrangement or contract was entered into to avoid the requirements of this title.

(4) FAMILY AND FAMILY MEMBER.—The terms "family" and "family member" mean, with respect to an employee, the spouse and children (including adopted children) of the employee.

(5) HEALTH BENEFIT PLAN.—The term "health benefit plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) that—

(A) provides medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise; and

(B) meets the requirements of section 311, except for purposes of sections 322(d)(3) and 401(b)).

(6) Health insurance region.—The term "health insurance region" means such a region designated under section 321.

(7) Insurer.—The term "insurer" means an entity qualified under the law of a State to offer insurance or provide health benefits in that State.

(8) Mental disorder.—The term "mental disorder" has the same meaning given such term in the International Classification of Diseases, 9th Revision, Clinical Modification.

(9) Nongovernmental employer.—The term "nongovernmental employer" means an employer not described in paragraph (3)(A)(ii).

(10) Regional insurer.—The term "regional insurer" means an insurer certified as a regional insurer under section 322.

(11) Secretary.—The term "Secretary" means the Secretary of Health and Human Services.

(12) State.—The term "State" includes the District of Columbia and, except for purposes of paragraph (7), also includes Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, and American Samoa.

Subtitle B—Requirements for Health Benefit Plans

SEC. 311. GENERAL REQUIREMENTS; PERMITTING ACTUARIALLY EQUIVALENT PLANS.

(a) General Requirements.—Subject to subsection (b), in order for a health benefit plan to meet the requirements of this subtitle, the plan shall—

(1) provide benefits for items and services in accordance with section 312;

(2) provide coverage of employees and family enrolled in the plan in accordance with section 313; and

(3) provide for premiums, deductibles, copayments, and coinsurance only in accordance with section 314.

(b) Actuarially Equivalent Plans Permitted.—

(1) In general.—A health benefit plan also meets the requirements of this subtitle notwithstanding that it does not meet one or more requirements of section 314 (relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses), if the actuarial benefits under the plan (as defined in paragraph (8)) are not less than the actuarial benefits that would have applied if the plan met the requirements described in subsection (a).

(2) Minimum requirements.—Nothing in this paragraph shall be construed as not requiring each plan to—

(A) meet the requirements of sections 312(a)(4) and 313; or

(B) establish a limit on out-of-pocket expenses under section 314(d), except that this subparagraph shall not be construed to require the establishment of the out-of-pocket limit described in section 314(d)(5)(B).

(3) Mental health benefits.—Notwithstanding any other provision of law, a health benefit plan may meet the requirements of section 312(a)(5) by including payment for any combination of benefits specified in subparagraphs (A) and (B) of such section if the plan includes payment for—

(A) benefits that are actuarially equivalent to the benefits for which payment is required under such subparagraphs; and

(B) both types of benefits described in each of such subparagraphs.

(4) Advisory board.—

(A) Establishment.—The Secretary shall establish an Advisory Board to advise the Secretary on development of actuarial equivalency standards and such other matters relating to the administration of this title as the Secretary or the board considers appropriate.

(B) Membership.—The Advisory Board shall consist of 12 members appointed by the Secretary, of which—

(i) four members shall be representatives of employers, who shall be experienced in the administration of and knowledgeable about health insurance and actively engaged in the management or design of health insurance programs, of which—

(I) two members shall be representatives of large businesses; and

(II) two members shall be representatives of small businesses;

(ii) two members shall be representatives of labor organizations, who shall possess the qualifications described in clause (i);

(iii) two members shall be representatives of the insurance industry, at least one of whom shall be knowledgeable about small group policies; and

(iv) two members shall be actuaries, who shall be experienced in the administration of and knowledgeable about health insurance programs.

(C) TERMS.—Members of the Advisory Board shall serve for a term of 4 years, except that members first appointed shall serve for staggered terms, as designated by the Secretary. A member may serve on the Board after the expiration of the term of the member until a successor has taken office as a member of the Board.

(D) COMPENSATION.—The members of the Advisory Board shall—

(i) receive compensation at the daily rate provided for persons in grade GS-18 established under section 5332 of title 5, United States Code, for each day actually engaged in the performance of the Board's functions; and

(ii) be entitled to receive actual and necessary travel expenses, including per diem in lieu of subsistence.

(E) DEVELOPMENT OF ACTUARIAL EQUIVALENCY VARIATIONS.—Not later than 6 months before the effective date of this Act, the Advisory Board shall develop and transmit to the Secretary—

(i) at least three model health plans that are actuarially equivalent to the minimum plan required under this subtitle;

(ii) a table of actuarial equivalency describing permitted variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health plan as a percentage increase or decrease in the minimum plan, with the table describing as many variations as possible in order to facilitate compliance with this Act; and

(iii) recommendations for procedures to facilitate the process by which an employer may certify actuarial equivalency for plan variations not provided in the model health plans or the table of actuarial equivalency and for the certification of multiple plans offered by the same employer.

(F) REVIEW OF CHANGES.—The Advisory Board shall review proposed changes to the benefit package required in the minimum plan and transmit a cost benefit analysis of such changes, along with recommendations, to Congress and the Secretary.

(5) TABLE OF ACTUARIAL EQUIVALENCY.—The Secretary shall publish, at least 3 months prior to the effective date of this Act, a table that describes variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health benefit plan as a percentage increase or decrease in the minimum plan. The table shall describe as many variations as feasible. In developing the table, the Secretary shall consider the recommendations of the Advisory Board established in paragraph (4).

(6) GOOD FAITH COMPLIANCE.—

(A) PLANS NOT CONSIDERED OUT OF COMPLIANCE.—In the case of health benefit plan variations not expressly provided for in the table or in the case of variations in which one or more elements of covered services, copayments, deductibles, and limits on out-of-pocket services are given a different relative value by the plan administrator than is provided by the table, the plan shall not be considered out of compliance with this Act if the plan—

(i) has established actuarial equivalency by a good faith process; and

(ii) has been certified as actuarially equivalent by an actuary meeting credentials established by the American Academy of Actuaries or by the Secretary.

(B) PLANS FOUND OUT OF COMPLIANCE.—Such plan shall be considered out of compliance if the Secretary has found the plan not to be in compliance. If the plan is found to be not in compliance, no penalty shall be levied against the plan for the prior period of noncompliance if the plan complies with subparagraph (A).

(7) MULTIPLE PLANS.—The Secretary shall establish by regulation streamlined procedures for an employer that has multiple health plans, at least one of which has been certified as at least actuarially equivalent, for the approval of an additional health plan that is at least actuarially equivalent to the certified plan.

(8) ACTUARIAL BENEFITS.—For purposes of this subsection, a plan's "actuarial benefits" are the amount by which the total of the amounts payable as benefits under the plan exceed the amount of the premiums, deductibles, copayments,

and coinsurance payable by the employee under the plan, as determined on an actuarial basis per enrollee for a plan year.

SEC. 312. REQUIREMENTS RELATING TO COVERED ITEMS AND SERVICES.

(a) In general.—Except as otherwise provided in this section, a health benefit plan shall include payment for—

(1) inpatient and outpatient hospital care, except that treatment for a mental disorder is subject to the special limitations described in paragraph (5)(A);

(2) inpatient and outpatient physician services, except that psychotheraphy or counseling for a mental disorder is subject to the special limitations described in paragraph (5)(B);

(3) diagnostic and screening tests;

(4) prenatal care and well-baby care provided to children who are 1 year of age or younger; and

(5)(A) inpatient hospital care for a mental disorder for not less than 45 days per year, except that days of inpatient care may be substituted for days of partial hospitalization according to a ratio established by the Secretary; and

(B) outpatient psychotheraphy and counseling for a mental disorder for not less than 20 visits per year provided by—

(i) a physician; or

(ii) a duly licensed or certified clinical psychologist or a duly licensed or certified clinical social worker, or a duly licensed or certified equivalent mental health professional, or a clinic or center providing duly licensed or certified mental health services.

(b) Exceptions.—Subsection (a) shall not be construed as requiring a plan to include payment for—

(1) items and services that are not medically necessary;

(2) routine physical examinations or preventive care; or

(3) experimental services and procedures.

(c) Scope and Duration of Certain Benefits.—Except as provided in subsection (b), a health benefit plan shall place no limits on the scope or duration of benefits described in paragraphs (1) through (3) of subsection (a).

(d) Specification of Prenatal Care and Well-Baby Care.—The Secretary shall by regulation prescribe, and annually revise, a schedule specifying the amount, duration, and scope of prenatal care and well-baby care required under subsection (a)(4). Subsection (b)(2) shall not apply to such care provided in accordance with such schedule.

(e) Limitations.—

(1) Panels and managed care systems.—Nothing in this Act shall prohibit a health benefit plan from providing benefits for the items and services described in this section through a panel or other form of managed care system, and from selecting particular health care providers or types, classes, or categories of health care providers to participate in such panel or managed care system. Such panel or managed care system shall provide, in accordance with regulations issued by the Secretary, reasonable access to care by plan participants.

(2) Different levels of payments.—Nothing in this Act shall prohibit a health benefit plan from establishing a different level of payments for reimbursement for different health care providers furnishing the benefits for the items and services described in this section.

(3) Health care providers.—During the 5-year period beginning on the effective date of this Act, no health benefit plan shall be required to utilize any health care provider (or type, class, or category of health care provider) to provide benefits for the items and services described in this section that were provided by the plan before January 1, 1988, other than the health care providers being utilized by the health plan on the January 1, 1988.

(f) Basis of Payment May Differ from Actual Charges.—

(1) In general.—Except as provided in paragraph (2), the requirement of payment for services described in subsection (a) shall not prevent an insurer from establishing a fee schedule or other basis of payment that is different from actual charges.

(2) Exception.—No such schedule or basis may be imposed that does not, according to regulations established by the Secretary, provide for payment that will be accepted to a substantial portion of providers, sufficient to achieve access to services covered by a plan, as payment in full for the covered service but for copayments and deductibles.

(g) New Small Businesses.—Notwithstanding any other provision of this title, in the case of a small business that employs 10 employees or less and that has been established for less than 2 years, the health benefit plan of the small business shall only be required to provide a limit on copayments and coinsurance in accordance with section 314(d).

(h) Mental Health Care.—

(1) Inpatient care.—For purposes of care provided under subsection (a)(5)(A), reimbursement for care shall be provided to a physician or duly licensed or certified clinical psychologist operating within the scope of practice of the physician or psychologist, as determined under State law. Nothing in this subsection shall be construed to modify hospital practices with regard to scope of practice, admitting privileges, or billing arrangements.

(2) Outpatient care.—

(A) Use of providers.—In the case of care provided under subsection (a)(5)(B), no health benefit plan shall be required to utilize any health care provider (or type, class, or category of health care provider other than physicians or duly licensed or certified clinical psychologists) to provide benefits for the items and services described in this section that were provided by the plan before January 1, 1988, other than the health care providers being utilized by the health plan on January 1, 1988.

(B) Standards for payment rendered by certain providers.—The Secretary shall establish standards that providers referred to in subsection (a)(5)(B)(ii) must meet to be eligible for payment under a health benefit plan established under this section.

SEC. 313. REQUIREMENTS RELATING TO TIMING OF COVERAGE AND PROHIBITION OF PREEXISTING CONDITION LIMITATIONS.

(a) Date of Initial Coverage.—In the case of an employee (and family members) enrolled under a health benefit plan provided by an employer, the coverage under the plan must begin not later than the latest of the following:

(1) 30 days after the day on which the employee first performs an hour of service as an employee of that employer.

(2) The first day on which the employer is required to meet the requirements of this title.

(3) In the case of a health benefit plan that—

(A) has been provided by the employer since May 19, 1985, and

(B) is provided by an employer that provides interim coverage under subsection (b),

the earlier of (i) 6 months after the day on which the employee first performs an hour of service as an employee of that employer, or (ii) the date for initiation of coverage under the plan (as in effect on May 19, 1987).

(4) In the case of an employer described in section 301(b)(2)(C)—

(A) 90 days after the date on which the employee first performs an hour of plan-covered service as an employee of the employer, except that if the initial waiting period is longer than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service as an employee of the employer; or

(B) 180 days after the day on which the employee first performs an hour of plan-covered service, except that if the initial waiting period is longer than 30 days, coverage under the plan shall continue for an equivalent period after the last day on which the employee performs an hour of plan-covered service.

(b) Interim Coverage Requirement.—Subsection (a)(3) shall only apply to an employer if the employer enrolls each employee, during the period the employee would otherwise be covered under a health benefit plan but for subsection (a)(3), in an interim plan that would meet the requirements of section 311 except that—

(1) the interim plan requires a premium that on a monthly basis exceeds the premium otherwise permitted under section 314(b), so long as the premium on a monthly basis does not exceed the monthly actuarial rate defined in section 314(b)(1)(B); or

(2) the interim plan requires deductibles and coinsurance that exceed the amounts otherwise permitted under section 314(b) and subparagraphs (A) and (B) of section 314(c)(1), so long as the interim plan meets the requirement of section 314(c)(1)(C) (relating to limitation on out-of-pocket expenses).

(c) Prohibition of Pre-existing Condition Provisions.—A health benefit plan may not exclude or otherwise limit any individual from coverage under the plan on the basis that the individual has (or at any time has had) any disease, disorder, or condition.

(d) DATE OF INITIAL COVERAGE AND MINIMUM SERVICE REQUIREMENTS FOR CERTAIN TEMPORARY EMPLOYEES.—A temporary employee described in section 303(2)(D)(iv) shall—

(1) become eligible for coverage under the health benefit plan of a temporary health services firm on the first day of the first calendar month following the completion of 750 hours of service during a period of 6 consecutive months and is employed by such firm on the eligibility date; and

(2) continue coverage under this title in each calendar month following the month of initial coverage, if such employee—

(A) has completed at least 100 hours of service in the immediately preceding calendar month; and

(B) has not been terminated before the first day of such calendar month.

SEC. 314. REQUIREMENTS RELATING TO PREMIUMS, DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND LIMIT ON OUT-OF-POCKET EXPENSES.

(a) ENROLLEE COST-SHARING PERMITTED.—A health benefit plan may require an enrollee to pay for premiums, deductibles, and coinsurance amounts for coverage under the plan, but only if the premiums, deductibles, copayments, and coinsurance do not exceed the limitations imposed under this section.

(b) LIMITATION ON PREMIUMS.—

(1) MONTHLY PREMIUM LIMITED TO 20 PERCENT OF ACTUARIAL RATE.—

(A) IN GENERAL.—A health benefit plan may not require an employee to pay a premium—

(i) for coverage for a period of longer than one month; or

(ii) the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate defined under subparagraph (B).

(B) MONTHLY ACTUARIAL RATE DEFINED.—For purposes of this title, the term "monthly actuarial rate" means, with respect to a health benefit plan in a plan year, the average monthly per enrollee amount that the employer providing the plan estimates, for enrollees under the plan during the year, would be necessary to pay for the total benefits required under the plan (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

(C) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this paragraph, a health benefits plan may provide for the premium to be applied, and the monthly actuarial rate—

(i) to be computed separately for employees without a family and for employees with a family, and

(ii) with respect to employees with a family, to be computed separately (I) for employees who have a spouse and any children, (II) for employees who have a spouse but no children, and (III) for employees who do not have a spouse but have children.

(D) APPLICATION ON BASIS OF PREMIUMS CHARGED EMPLOYEES.—For purposes of this paragraph, if a health benefit plan charges an employee for a share of the premium, the plan shall establish a separate category to compute the premium. The category shall be family coverage in which a spouse receives primary health insurance coverage from another plan. The premium shall be established based on actual or projected plan experience or according to a formula established by the Secretary.

(2) NO PREMIUM FOR LOW INCOME EMPLOYEES.—

(A) IN GENERAL.—A health benefit plan may not require a premium for an employee whose hourly wage rate is less than the hourly wage rate specified in subparagraph (B).

(B) HOURLY RATE.—The hourly wage rate specified in this subparagraph for premiums paid in a plan year beginning in—

(i) 1988, is $4.19, or

(ii) a subsequent year, is the hourly wage rate specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the rate computed under clause (ii) is not a multiple of 1 cent it shall be rounded to the next highest multiple of 1 cent.

(3) PAYMENT OF PREMIUMS.—An employee enrolled under a health benefit plan is liable for payment of premiums required under that plan in accordance with this subsection.

(4) WITHOLDING PERMITTED.—No provision of State law shall prevent an employer of an employee enrolled under a health benefit plan established under this title from withholding the amount of any premium due by the employee from the payroll of the employee.

(c) LIMITATION ON DEDUCTIBLES.—

(1) IN GENERAL.—Except as permitted under paragraph (2), a health benefit plan may not provide, for benefits provided in any plan year, for a deductible amount—

(A) that exceeds—

(i) with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, for a plan year beginning in—

(I) the first calendar year that begins more than 1 year after the date of the enactment of this Act, $250; or

(II) for a subsequent calendar year, the limitation of deductions specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

(ii) with respect to benefits payable for items and services furnished to any employee with a family member enrolled under the plan, for a plan year beginning in—

(I) the first calendar year that begins more than 1 year after the date of the enactment of this Act, $500; or

(II) for a subsequent calendar year, the limitation of deductions specified in this clause for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year; and

(B) for prenatal care or well-baby care described in section 312(a)(4).

If the limitation of deductions computed under subparagraph (A)(i)(II) or (A)(ii)(II) is not a multiple of $10, it should be rounded to the next highest multiple of $10.

(2) WAGE-RELATED DEDUCTIBLE.—A health benefit plan may provide for any other deductible amount instead of the limitations under—

(A) clause (i) of paragraph (1)(A), so long as the amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year; or

(B) clause (ii) of paragraph (1)(A), so long as the amount does not exceed (on an annualized basis) 2 percent of the total wages paid to the employee in the plan year.

(d) LIMITATION ON COPAYMENTS AND COINSURANCE.—

(1) IN GENERAL.—Subject to paragraphs (2) through (4), a health benefit plan may not—

(A) require payment of any copayment or coinsurance for an item or service for which coverage is required by this title in an amount that exceeds 20 percent of the cost of the item or service;

(B) require payment of any copayment or coinsurance for prenatal care or well-baby care described in section 312(a)(4); or

(C) require payment of any copayment or coinsurance for items and services required under section 312 furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in paragraph (5)(B)).

(2) EXCEPTION FOR PREFERRED PROVIDERS.—If a health benefit plan establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under paragraph (1) in the case of items and services furnished by nonparticipating providers.

(3) EXCEPTION FOR IMPROPER UTILIZATION.—A health benefit plan may provide for copayment or coinsurance in excess of the amount permitted under paragraph (1) for any item or service that an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

(4) MENTAL HEALTH CARE.—In the case of care provided under section 312(a)(5)(B), a health benefit plan may not require payment of any copayment or

coinsurance for an item or service for which coverage is required by this title in an amount that exceeds 50 percent of the cost of the item or service.

(5) LIMIT ON OUT-OF-POCKET EXPENSES.—

(A) OUT-OF-POCKET EXPENSES DEFINED.—In this section, the term "out-of-pocket expenses" means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and family covered under the plan.

(B) OUT-OF-POCKET LIMIT DEFINED.—In this section, except as provided in subparagraph (C), the term "out-of-pocket limit" means for a plan year beginning in—

(i) the first calendar year that begins more than 1 year after the effective date of this Act, $3,000; or

(ii) for a subsequent calendar year, the out-of-pocket limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (United States city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under clause (ii) is not a multiple of $10, it should be rounded to the next highest multiple of $10.

(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health benefit plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to an employee and the employee's family, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

Subtitle C—Certification of Regional Insurers

SEC. 321. DESIGNATION OF HEALTH INSURANCE REGIONS.

The Secretary shall designate by regulation six, seven, or eight health insurance regions for purposes of this subtitle.

SEC. 322. PERIODIC CERTIFICATION OF REGIONAL INSURERS.

(a) IN GENERAL.—The Secretary shall establish procedures for the periodic certification of regional insurers for each health insurance region. Any insurer may apply to be certified as a regional insurer for a region. Each insurer applying to be certified that meets the eligibility criteria established by subsection (b) may be certified.

(b) ELIGIBILITY FOR CERTIFICATION.—No applicant may be certified as a regional insurer unless the applicant—

(1) meets standards of financial stability established by the Secretary;

(2) meets standards for quality and type of services established by the Secretary;

(3) meets the requirements of section 323;

(4) agrees to enroll any group in the region applying for enrollment that is eligible to enroll with a regional insurer;

(5) agrees to offer only plans and plan options approved by the Secretary to organizations required to enroll with a regional insurer;

(6) agrees that if it offers a managed care program to any organizations within the region, it will also make that managed care program, with benefits packages meeting the requirements of section 323, available in its capacity as regional insurer; and

(7) agrees to allow its offerings to be listed in material distributed by the Secretary, described in such form as the Secretary may prescribe, and to enroll persons who wish to enroll by mail by accepting a completed form to be contained in such material.

(c) APPLICATIONS.—No insurer may be certified as a regional insurer unless it submits to the Secretary an application for such certification in such form and at such time as the Secretary prescribes. Each such application shall include—

(1) specific descriptions of each of the health benefit plans the insurer proposes to offer under section 323(a) as a regional insurer; and

(2) such information as is needed for the Secretary to consider the items described in subsection (d).

(d) CONSIDERATIONS.—In reviewing applications for certification as regional insurers, the Secretary shall consider, with respect to each applicant—

(1) the price of health benefit plans proposed to be offered by the applicant;

(2) the quality and types of services to be provided under the plans;

(3) the experience of the applicant in providing and managing health benefit plans; and

(4) the financial stability of the applicant.

(e) Certification.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first certify regional insurers for each health insurance region. The Secretary shall publish in the Federal Register a list of the regional insurers certified under this section.

(f) Evaluation and Decertification.—The Secretary shall periodically evaluate the performance of regional insurers under this subtitle. If the Secretary finds that a regional insurer is not substantially meeting the requirements of this subtitle, the Secretary, after notice and opportunity for a hearing, may terminate the certification of the insurer.

SEC. 323. REQUIREMENTS OF REGIONAL INSURERS.

(a) In General.—

(1) Minimum requirements.—Each regional insurer shall offer, to employers located in its health insurance region at least—

(A) two indemnity plans described in subsection (b)(1)—

(i) one of which provides only the minimum benefits required of a health benefit plan; and

(ii) the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region; or

(B) two managed-care plans described in subsection (b)(2)—

(i) one of which provides only the minimum benefits required of a health benefit plan; and

(ii) the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region.

(2) Additional benefits.—In the case of plans described in subparagraph (A)(i) or (B)(i) of paragraph (1), a regional insurer shall provide optional, additional benefits for an additional premium. Such options shall include variations in copayments, deductibles, and the catastrophic cap, and additional services and categories of providers. Such benefits shall be subject to approval by the Secretary and, to the maximum extent feasible, shall be standard across carriers within a region.

(b) Plans Described.—

(1) Indemnity plan.—An indemnity plan described in this subparagraph is a health benefit plan—

(A) that makes payment with respect to items and services furnished by any provider licensed in the State to provide the items and services if—

(i) the provider is a type of provider covered under the plan;

(ii) the provider is not excluded from receiving payment under the plan on the basis of fraud, abuse, or incompetence (as determined under the rules and procedures of the plan); and

(iii) the plan does not differentiate in payment to providers under the plan based on a contractual arrangement (or lack thereof) between the plan and the provider; and

(B) under which an individual incurs an obligation or makes payment for covered item or service and the plan reimburses the individual or the provider of such services for the amounts payable for such item or service under the plan.

(2) Managed-care plan.—A managed-care plan described in this subparagraph is a health benefit plan under which items or services must generally be furnished either by—

(A) providers having a contractual relationship with the plan; or

(B) providers included on a list specified by the plan that consists of a group of providers in a State that is more restricted than all licensed providers in the State.

(c) Community-Rated Premiums.—Subject to section 324(b)(2), each regional insurer shall fix premiums for the plans required under subsection (a) under a community rating system for all employers. An insurer may not set or adjust such premiums based on the age or gender of employees (or their families), on other factors relating to the projected or actual use of health services under the plan, or on geographical location within the region.

SEC. 324. MISCELLANEOUS PROVISIONS.

(a) Subcontracts.—Each regional insurer may enter into subcontracts with other entities in carrying out this subtitle.

(b) ARRANGEMENTS WITH SMALL BUSINESSES.—

(1) IN GENERAL.—The Secretary shall encourage regional insurers to enter into appropriate arrangements with entities representing groups of small businesses (such as small business service bureaus and chambers of commerce) for the provision of administrative services with respect to small businesses enrolled in plans offered by the insurers.

(2) PREMIUM REDUCTION.—Each such insurer shall reduce the premiums otherwise charged for such plans to such small businesses by an amount that reflects the value of such administrative services.

(c) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance and enrollment forms to employers required under section 301(b)(2) to provide health benefit plans of regional insurers. In carrying out this subsection, the Secretary shall, to the maximum extent feasible, enter into contracts (to the extent and in such amounts as may be provided in advance in appropriation Acts) with small business service bureaus, chambers of commerce, and other entities with experience in providing health insurance services to small businesses.

Subtitle D—Regulations and Enforcement

SEC. 331. REGULATIONS.

(a) PROPOSED RULES.—Within 4 months after the date of enactment of this Act, the Secretary shall publish a notice of proposed rule making to carry out this title.

(b) FINAL RULES.—Within 9 months after the date of enactment of this Act, the Secretary shall promulgate final rules to carry out this title. Such notice and final rules shall be made in accordance with section 553 of title 5, United States Code.

SEC. 332. ENFORCEMENT.

(a) CIVIL MONEY PENALTY AGAINST PRIVATE EMPLOYERS.—

(1) 10 PERCENT OF TOTAL WAGES.—Any nongovernmental employer that does not comply with section 302(c) or the requirements of section 2301(a) of the Public Health Service Act or section 201(a) of the Fair Labor Standards Act of 1938 in any calendar year shall be subject to a civil penalty of not more than 10 percent of the total amount of the employer's expenditures for wages for employees in that year.

(2) ASSESSMENT PROCEDURE.—A civil money penalty under this subsection shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity to present its views on such charge.

(3) AMOUNT OF PENALTY.—In determining the amount of the penalty, or the amount agreed on in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of noncompliance by the Secretary.

(4) JUDICIAL REVIEW.—In any civil action brought to review the assessment of such a penalty or to collect such a penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of the penalty, unless in a prior action such a trial de novo was held on the assessment.

(b) LIABILITY TO INDIVIDUALS FOR DAMAGES.—Any nongovernmental employer that knowingly does not comply with section 302(c) or the requirements of section 2301(a) of the Public Health Service Act or section 201(a) of the Fair Labor Standards Act of 1938 shall be liable for damages (including health care costs incurred) to the employee or the employee's family resulting from such failure to comply.

(c) STATE INELIGIBILITY FOR PUBLIC HEALTH SERVICE ACT FUNDS.—

For a provision making States and political subdivisions thereof ineligible for funds under the Public Health Service Act if they fail to enroll employees under health benefit plans, see section 2301(b)(1) of such Act.

(d) INJUNCTIVE RELIEF.—

(1) IN GENERAL.—Subject to paragraph (3), any individual injured or adversely affected or aggrieved by a violation of the requirements of section 302(c), section 2301(a) of the Public Health Service Act, or section 201(a) of the Fair Labor Standards Act of 1938 may bring an action in an appropriate district court of the United States to enjoin such a violation or to compel compliance with such requirement.

(2) COSTS AND FEES.—In any judicial proceeding under this subsection, the court, in its discretion, may allow the party bringing the action a reasonable attorney's fee as part of costs if the party substantially prevails.

(3) NOTICE.—At least 15 days before the date a party brings an action under this subsection, the party shall give notice by registered mail to the Secretary and the Attorney General. Such notice shall state the nature of the alleged violation and the court in which the action will be brought.

TITLE IV—EFFECTIVE DATE

SEC. 401. EFFECTIVE DATE.

(a) GENERAL RULE.—Except as otherwise provided in this section, this Act, and the amendments made by this Act, shall take effect on January 1 of the second year that begins after the date of the enactment of this Act.

(b) EXISTING PLANS.—In the case of an employer that, on the date of the enactment of this Act, has in effect a health benefit plan, this Act, and the amendments made by this Act, shall not apply until the first day of the second plan year that begins after the date of the enactment of this Act.

(c) STATE AND LOCAL GOVERNMENTS.—In the case of an employer whose revenue is raised by a taxing authority, a health benefit plan maintained by the employer shall not be required to meet the requirements of section 314(b)(1)(A)(ii) until the first day of the third plan year that begins after the date of the enactment of this Act. During the period beginning on the effective date prescribed under subsections (a) and (b) and ending on the first day of the third plan year that begins after the date of the enactment of this Act, employee participation in such plan shall be voluntary unless otherwise required by the plan.

(d) ADVISORY BOARD.—Section 311(b)(4) shall take effect on the date of enactment of this Act.

(e) SMALL BUSINESSES.—

(1) IN GENERAL.—Except as provided in paragraph (2), in the case of a small business that employs 5 employees or less, this Act, and the amendments made by this Act, shall not apply until January 1 of the fourth year that begins after the date of the enactment of this Act.

(2) CATASTROPHIC COVERAGE ONLY.—During the period beginning on the effective date prescribed in paragraph (1) and ending on December 31 of the sixth year that begins after the date of the enactment of this Act, in the case of a small business that employs 5 employees or less, the health benefit plan of the small business shall only be required to provide a limit on copayments and coinsurance in accordance with section 314(d).

SEC. 402. POLICY RESPECTING ADDITIONAL BENEFITS.

(a) IN GENERAL.—After the date of the enactment of this Act, no employer shall be required under title III to provide any health benefit in addition to the benefits required to be provided under section 312(a) (as in effect on the date of the enactment of this Act) unless—

(1) such additional health benefit is for a service that State medicaid plans (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) are required to cover for individuals receiving cash assistance under part A of title IV of such Act (42 U.S.C. 601 et seq.); and

(2) before the enactment of such requirement, the benefits and costs of requiring the provision of such additional health benefit have been analyzed and considered by Congress.

(b) REPORTS.—

(1) IN GENERAL.—In carrying out subsection (a)(2) with respect to the consideration of a proposed additional health benefit, Congress shall request a report from the Office of Technology Assessment, the Institute of Medicine of the National Academy of Sciences, or a public or nonprofit entity with expertise relating to health benefits. Any such report shall—

(A) analyze and summarize such proposed additional health benefit; and

(B) contain an estimate of the economic and health impacts of such proposed additional health benefit.

(2) CONSULTATION.—Any such report shall be prepared in consultation with interested members of the public and with individuals and entities having expertise with respect to such proposed additional health benefit.

III. History of Legislation

S. 1265 was introduced by Senators Kennedy and Weicker on May 21, 1987, and was referred to the Senate Committee on Labor and Human Resources. The Committee held three hearings on the legislation: May 19; June 24; and November 4, 1987. The purpose of the hearings was to examine the nature of the uninsured problem, its causes and its effects, and to understand who in the population is affected by the lack of coverage. The Committee was also interested in examining the barriers to access to insurance, especially for smaller employers. Finally, the hearings provided interested groups and individuals an opportunity to comment on S. 1265.

At these hearings, testimony was heard from a broad spectrum of witnesses with varying perspectives on the problem of the medically uninsured and under-insured. These included individuals who have suffered from lack of health insurance coverage, the Small Business Administration, the Council of Economic Advisers, representatives of small and large businesses, representatives of organized labor, representatives of providers of health care services, representatives of the health insurance industry, health policy experts and the Congressional Budget Office. The witness list follows:

MAY 19, 1987

Panel I. Citizens

Jackie Davison, Elyria, Ohio.
Helen Lipowsky, Danville, Illinois.
Nina Pettiford, Pittsburgh, Pennsylvania.

Panel II. Providers

Jack Owen, American Hospital Association.
Sister Mary Eileen Wilhelm RSM, Catholic Health Association.
Jerold M. Aronson, M.D., American Academy of Pediatrics.

Panel III. Experts

Karen Davis, Ph.D., Professor of Economics Johns Hopkins University.

Gail Wilensky, Ph.D., Project Hope.

JUNE 24, 1987

Panel I. Business

Robert L. Crandall, President and Chairman of American Airlines.

Walter B. Maher, Director of Employee Benefits of Chrysler Motors Corporation.

Karl D. Bays, Chairman of Baxter Travenol Laboratories.

Panel II. Labor

Owen Bieber, President UAW.

John J. Sweeney, International President of Service Employees International Union, AFL-CIO.

Panel III. Insurance Experts

Philip Briggs, Vice-Chairman of the Board of Metropolitan Life Insurance and Affiliated Companies.

Carson Beadle, Managing Director William M. Mercer-Meidinger-Hansen, Incorporated.

Panel IV. Business Associations

Willis B. Goldbeck, President Washington Business Group on Health.

Robert E. Patricelli, President ValueCare, Inc. on behalf of the U.S. Chamber of Commerce.

Gerald R. Rudd, Senior Vice President for Human Resources Albertson's Incorporated on behalf of the Food Marketing Institute.

Mark J. Ugoretz, Executive Director of the ERISA Industry Committee.

Panel V. Insurance associations

Bernard R. Tresnowski, President of Blue Cross and Blue Shield Association.

Carl J. Shramm, President of the Health Insurance Association of America.

Panel VI. Small business

Francis R. Carroll, President of the Small Business Service Bureau, Incorporated.

Alice Griffin, President of Griffin Pension Services, Incorporated for the Small Business Association of New England.

Frank S. Swain, Chief Counsel for Advocacy for the U.S. Small Business Administration.

NOVEMBER 4, 1987

Panel I

Tom Moore, Council of Economic Advisors.

Karen Davis, Ph.D., Professor of Economics, Johns Hopkins University.

Panel II

Ed Gramlich, Acting Director, Congressional Budget Office.

Panel III

F. Gerald Adams, Professor of Economics, University of Pennsylvania.

Gordon Trapnell, President, Actuarial Research Corporation.

Gary Robbins, President, Fiscal Associates, on behalf of Institute for Research on the Economics of Taxation.

The Committee ordered the legislation reported out with an amendment in the nature of a substitute on February 17, 1988 by a vote of 10–6. An amendment to the substitute by Senators Harkin, Metzenbaum, Mikulski and Simon was adopted by voice vote.

IV. BACKGROUND AND NEED FOR LEGISLATION

GAPS IN HEALTH INSURANCE COVERAGE

Almost 68 percent of the American population under age 65 has health insurance coverage through private group plans sponsored by employers. Another 8 percent are covered through the two major Federal Government programs, Medicare and Medicaid, and a smaller group are either covered by military programs or purchase individual policies through the private health insurance market. However, an estimated 37 million individuals—one in every six Americans under age 65—are without any health insurance coverage, public or private.

In a nation in which health insurance is primarily obtained at the workplace, it is of particular concern that over two-thirds of the uninsured under age 65 (24 million people) are workers or dependents of workers. Over 7 million uninsured children live in families where there is a working head of the household; three hundred thousand of these children are disabled.

In addition to the 37 million Americans who are without any health insurance, there are millions more who are underinsured for the costs of catastrophic out-of-pocket expenses for health care. A recent report by the Department of Health and Human Services (HHS) found that in 1984 approximately 60 million privately insured persons under age 65 would have been subject to unlimited out-of-pocket expenses if faced with an extraordinarily expensive illness or accident. Fifty-three million of these individuals were employed. More than 2 million families every year experience catastrophic out-of-pocket costs in excess of $3,000 that insurance does not cover. HHS estimates that 7 million people who had insurance in 1984 would have become uninsurable because of their health status if they had lost their existing coverage. (A person is uninsurable if he or she cannot obtain medically underwritten insurance, usually because of poor health status, previous medical history or a hazardous occupation. However, such a person might be able to get coverage under a group policy through an employer or might have acquired coverage before becoming ill. Thus, the number of persons who are at risk of being uninsurable is greater than the number who are actually uninsured for this reason.)

THE GROWTH OF THE UNINSURED POPULATION

The size of the uninsured population in the United States has been growing. In the 1970s, an estimated 13 to 14.5 percent of the population was uninsured; today, close to 18 percent of the population has no coverage. The Congressional Budget Office (CBO) has estimated that for the period 1980 through 1987 the number of uninsured Americans rose by 7.3 million.

It is sometimes argued that the number of uninsured peaked during the 1981–1982 recession and would decline as the economy recovered and employment expanded. However, a recent analysis by the CBO concludes that the number of uninsured Americans under age 65 did not decline after the recession, but has continued to rise. This is partly because the proportion of the population covered by employment-based coverage has not kept pace with the increase in the nonelderly population. While the total nonelderly population grew by 6 percent between 1980 and 1987, employment-based insurance grew by only 3 percent. In addition, the number of Americans covered by other, largely private, insurance declined by 10 percent. Medicaid and Medicare, however, covered 17 percent more people under age 65 in 1987 than in 1980. CBO concluded that the net effect of these changes was a 25 percent rise in the number of uninsured.

There are several possible reasons why the proportion of Americans with employer-sponsored health insurance is declining. One is that the American economy is experiencing a shift from jobs that have traditionally carried health insurance such as manufacturing and transportation, to jobs that often do not, especially service and retail trade jobs. Another reason is that dependent coverage by employer plans is declining. CBO has suggested that this lack of coverage for dependents may reflect less generous contributions by employees as they attempt to control the rising costs of fringe benefits. The trend toward reduced employer contributions for dependent coverage is revealed in data collected from medium and large size employers by the Department of Labor. In 1980, 51 percent of employees received health insurance coverage for their families that was wholly paid for by their employers; that percentage had dropped to 35 percent by 1986.

While the lack of insurance is associated with certain types of jobs, it is also associated with the size of the employer. As firm size decreases, the likelihood of coverage also decreases, with employees of very small firms (businesses of 10 or less) the least likely to have coverage. A 1986 survey by the Small Business Administration reports that while almost all firms with 500 or more workers offered health benefits, such benefits were offered by 78 percent of firms with 10 to 24 workers and 46 percent of firms with fewer than 10 workers. Nevertheless, the problem of noncoverage is not unique to small business. Almost 60 percent of employees of smaller firms (businesses of 25 employees or less) work for businesses that offer coverage, while almost one quarter of uninsured employees work for very large firms with 1,000 or more employees.

FINANCING HEALTH CARE FOR THE UNINSURED

People who are uninsured or underinsured can sometimes receive free or subsidized health care if they do not have the ability to pay for their care out-of-pocket. However, the unpaid portion of their care falls on others to pay. These "uncompensated care" costs are shifted onto health care providers, state and local governments, or onto other health care payers, including privately insured patients and employers who provide health insurance coverage.

Such cross-subsidies are especially burdensome for employers who provide health insurance because they, in effect, subsidize those employers who do not provide coverage. First, they pay premiums and provider charges that are priced to cover not only the direct cost of providing health care services to their workers, but also other costs borne by the providers of health care for uninsured persons, a majority of whom are uninsured workers. In addition, employers who provide health benefits subsidize other employers by insuring many of the latter's workers through family coverage.

The growth in the number of uninsured has occurred at a time when increased competition and changes in reimbursement policy by private insurers and the Federal Government have made it more difficult for hospitals to shift the costs of treating uninsured patients to other payers. Consequently, a declining number of hospitals are willing to admit the uninsured, thus jeopardizing access to hospital care for the uninsured patient and increasing the uncompensated care burden of those hospitals that will admit such patients. There is in this combination of forces a potential for even greater barriers to access to care. As competition continues to reduce the ability of hospitals to cost-shift, more and more uninsured patients will be sent to fewer and fewer hospitals. Public hospitals are finding it especially difficult to care for the disproportionate share of uninsured and underinsured patients that they treat. While public hospitals account for only 22 percent of all hospital care, they provide 40 percent of all uncompensated care.

SMALL EMPLOYERS AND HEALTH INSURANCE

As noted above, a substantial portion of the working uninsured are employed by firms with fewer than 25 employees. Lack of coverage among employees of smaller firms is caused by the higher premium costs for small employers, the administrative burden of selecting a plan and paying the premiums, and the lack of availability of health insurance for many small businesses as a result of the practice of medical underwriting. Small employers who do not provide coverage to their employees indicate in surveys that health insurance is too expensive, and that they do not have the time or personnel to navigate around the complex range of health insurance and prepaid health care options. In fact, the costs of insurance for small employers range from 10 to 40 percent higher than for large employers, with small groups of nine or less experiencing the highest premiums. According to testimony by the Actuarial Research Corporation before the Committee, the retention rate (the portion of the insurance premiums retained by the insurance company to cover sales, administration, and profit) for businesses of 25 or less averages 25%; for large businesses the corresponding figure is 5%.

In testimony before the Senate Labor and Human Resources, Committee and the House and Senate Small Business Committees, witnesses explained that insurance companies charge smaller employers more for health coverage because of the higher costs of acquiring their business, the higher risk of insuring smaller groups, and the higher costs of administering small group plans. Acquisition costs include marketing and underwriting the policies.

A major reason that marketing to small employers is more expensive is that the small employer market is more volatile: fewer smaller businesses actually purchase policies, and when they do, they are less likely to renew them.

Another concern for insurance companies in acquiring smaller employers is the higher risk of providing coverage to small groups. With large groups the risk of incurring a loss—of having to pay claims on the policy—is spread out over a large number of individuals. In addition, there is less likely to be adverse selection in large groups, which is the tendency of poorer than average risks to purchase coverage. Especially in large employer plans where the employer pays a major share of the premium, most employees are likely to elect coverage. In a small employer group, however, particularly those groups with less than ten participants, the risk of a loss to the insurance company is spread over only a few individuals, and the probability of adverse selection is high. This is especially true of small employers with young, low-wage workers. The employees who elect coverage are likely to be those who anticipate using medical services. In addition, the owner of the business may decide to purchase group coverage primarily to gain coverage for a sick member of his or her own family.

To limit adverse selection, insurers generally individually underwrite small firms, especially those with less than 10 employees. This is a process in which the insurer gathers and analyzes information on the health status of each employee in order to arrive at a premium rate. The rate will, in addition, reflect the age, sex, location and type of business. If the insurer decides to sell the employer a policy, it will often write into the policy a preexisting condition clause that will either exclude any high risk employees from coverage under the employer's group plan or will delay or exclude coverage of such employees' preexisting conditions. An employer that is engaged in hazardous activities (for example, toxic waste disposal or munitions manufacturing) may find it impossible to buy insurance. Finally, many insurers will wholly or partially experience rate the coverage for small employers. High losses in one year will drive up the premiums charged in the next year.

The expense for the insurance company of individually underwriting a small employer plan is passed along to the employer in the form of higher premiums. Also included in the premium rate is the relatively higher overhead costs to administer small employer plans. Without the economies of scale that are achieved in administering large firms, insurers experience higher costs for billing, maintenance of accounts and tracking of enrollment status.

In a report on catastrophic illness, the Department of HHS found that the availability of insurance for smaller employers may be declining as a result of insurers using "aggressive" under-writing practices to sell relatively inexpensive coverage to some groups and more costly coverage to the rest:

> This process 'skims' small employers with healthy workforces out of the general market, leaving employers with less healthy workforces to maintain the coverage they have or to enroll in Blue Cross/Blue Shield. Local Blue Cross/Blue Shield plans, in part because of tax advantages they enjoy as non-profit companies, turn down applicants substantially less frequently than do other commerical insurers. The result is to reduce the number of healthy enrollees over whom the risk of insurance payout is spread. Because renewal premiums are consequently likely to rise rapidly (the healthy groups leave, and the insurance experience of the remainder becomes increasingly worse as a

result), employers with employee groups found by potential insurers to represent excess risk will find coverage progressively harder to secure and to afford.

Many policy analysts, including Gail Wilensky of Project Hope and Randall Bovbjerg of the Urban Institute, have suggested that the costs of purchasing insurance for smaller employers can be reduced through various pooling mechanisms designed to simplify plan administration, and take advantage of a basic principle of insurance, that is, to spread the risk over the largest possible group. One such mechanism is the multiple employer trust (METs). Broadly defined, METs are formed for the purpose of combining a number of employers having two to 25 employees each into a single group for insurance purposes. Insured METs obtain a group insurance contract from an insurance company, which maintains a direct role in administering the MET. (METs can also self-insure, but many have run into substantial financial difficulties because they have set unrealistically low rates in order to attract customers, or have failed to set aside sufficient reserves to meet their costs.) Billing is simplified because the MET coordinates the process for all the participating firms. In addition, the MET can sometimes negotiate preferred provider arrangements that would not be possible for individual small firms.

Despite these advantages, METs have not been very successful in expanding small employer access to health insurance. The experience of METs and similar pooling arrangements, such as the Council of Smaller Enterprises in Ohio, suggests that existing METs have been unable to offer insurance at low enough rates. Because participation by firms in a MET is voluntary, insurers worry about adverse selection. In response, they apply underwriting standards and base the premiums on the insurance experience of the group's previous year (referred to as "experience-rating"). Once this is done, the better risk companies seek less expensive coverage outside the MET, leaving the MET with the poorer risks and higher premiums.

These limitations on METs and similar pooling arrangements have stimulated the search for more effective mechanisms for expanding the availability of affordable health insurance to small employers. One option would be to establish regional insurers for small employers, in which all employers below a certain size and their employees were required to participate. The regional insurers would offer a variety of health insurance plans, including managed care options such as health maintenance organizations. Such an arrangement would minimize adverse selection and hold down marketing and administrative costs because it would combine both good and bad risks in a pool large enough to spread out the risks, would provide for economies of scale in the administration of the benefits, would minimize the frequent enrollment and disenrollment characteristic of the small employer market, and would eliminate the cost of medical underwriting. In testimony prepared for the Senate Labor and Human Resources Committee, the Actuarial Research Corporation estimated that this type of pool, operated at a regional level and community-rated, could cut premiums by 10 percent compared to similar health benefit plans on the current market, and as much as 25 percent if managed care options were included in the plans. Achievement of these economies would be dependent, however, on legal requirements that all employers must purchase insurance for their employees and that all employers within a defined category would participate in the regional insurance program.

STATE MANDATED BENEFIT LAWS AND ERISA

An added complication faced by employers that purchase health insurance coverage for their employees is State mandated benefit laws. In the aggregate, the States have enacted more than 600 different laws mandating benefits if a plan provides health coverage to its participants by purchasing health insurance. These mandated benefit laws include specific services, the services of specific providers, as well as requirements that health insurance plans provide for continuation and conversion options. While mandated benefit laws may have contributed to increased access to certain services, they may also have contributed to increases in the costs of health insurance for conventionally-insured companies. Moreover, they created administrative problems for employers that are based in more than one State.

State mandated benefit laws have forced many larger firms to become self-insured in order to provide uniform benefits to their employees and to achieve greater flexibility in benefit design. The health benefits of self-insured companies are regulated under the ERISA, a Federal statute, and do not have to comply with state mandated benefits laws, since the States are preempted by ERISA from regulating self-insured health benefit plans. However, ERISA itself provides for very limited regulation of self-insured plans. Consequently, employers operate on an uneven playing field, where those that are conventionally insured must comply with State regulations, including mandated benefit laws, while those that are self-insured are able to operate in a less restrictive regulatory environment. S. 1265 extends the advantages of a uniform national regulatory environment to both insured and self-insured plans.

CONSEQUENCES OF LACKING HEALTH INSURANCE COVERAGE

Significant adverse consequences are associated with the lack of health insurance coverage. For the individual, sporadic or prolonged noncoverage can lead to poor health outcomes and crippling financial losses. Uninsured individuals are less likely to use health services and are more likely to be in poorer health than the insured population. In addition, Americans without health insurance may face extended delays in seeking and obtaining needed health care. Such delays can result in poorer health and higher care costs if and when the individual obtains treatment.

CBO has estimated that the 37 million uninsured under age 65 use one third less health care on average than people that are insured. Using different data, a recent study for the Robert Wood Johnson Foundation found that in 1986, the uninsured had approximately 40 percent fewer ambulatory visits (such as physician visits) and 19 percent fewer hospitalization than the insured. Most striking, the Johnson study found that in 1986, 15 million Americans did not receive medical care for financial reasons. An estimated 1 million of these individuals tried to obtain needed care but were denied it because they could not pay; an additional 14 million did not even seek care because they knew they could not affort it.

The consequences of the lack of adequate coverage have been dramatically documented with respect to infants and pregnant women. A recent study by the General Accounting Office (GAO) of pregnant women who either had no health insurance or were on Medicaid found that 63 percent obtained insufficient prenatal care. Of the babies born to these women, 12.4 percent were of low birth weight, almost twice the percent of low birth weight babies nationwide. The GAO reports that, in 1985, 67 percent of infant deaths during the first 4 weeks of life and 50 percent of deaths in the first year of life were attributed to low birth weight. Surviving infants were at increased risk of serious illness or lifelong handicaps. The cost to society of low birth weight infants for 1985 was estimated by the American Academy of Pediatrics to be as high as $3.3 billion, at an average cost of $14,698 per infant. The prevalence of noncoverage among pregnant women may help to explain why the United States has one of the highest infant mortality rates of the industrialized world-tied for last place among twenty industrialized nations in a 1987 study by the Childrens' Defense Fund.

THE MINIMUM HEALTH BENEFITS FOR ALL WORKERS ACT OF 1988

The "Minimum Health Benefits for all Workers Act of 1988" has been designed to assure basic health insurance coverage for 23 million working Americans and their families who are currently uninsured. In addition, the legislation will require provision of catastrophic coverage to total of 53 million workers and their family members who now lack it. The bill will result in a significant reduction in the costs of unreimbursed (uncompensated) care for providers and for employers that now provide health insurance. Finally, it will assure that affordable health insurance is available to employers of all sizes.

V. TABULATION OF VOTES IN COMMITTEE

The Committee considered and adopted without objection an amendment in the nature of a substitute offered by Chairman Kennedy.

An amendment to the substitute providing a phase-in period for small businesses was offered by Senators Harkin, Metzenbaum, Mikulski, and Simon. It was adopted by voice vote.

The Committee considered a motion to favorably report the bill as amended. By a rollcall vote of 10 to 6, the Committee agreed to the motion.

YEAS	NAYS
Kennedy	Hatch
Adams	Cochran
Dodd	Humphrey
Matsunaga	Stafford
Metzenbaum	Thurmond
Mikulski	Quayle

YEAS
Pell
Simon
Weicker

VI. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 22, 1988.

Hon. EDWARD KENNEDY,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

DEAR SENATOR: The Congressional Budget Office has reviewed S. 1265 (the "Minimum Health Benefits for All Workers Act of 1987") as ordered reported by the Senate Committee on Labor and Human Resources on February 17, 1988, and has prepared an estimate of its costs to the federal government. The estimated fiscal impact of S. 1265 is shown as steady-state estimates for a year in which the bill is assumed to be fully implemented.

The approach and major assumptions of this estimate are similar to those outlined in CBO's testimony before the Committee on November 4, 1987. The changes in the estimate reported here reflect changes in baseline budget estimates, changes in the bill, a change of the year for which the estimate is reported, as well as refinements in the estimate. Because one of the major uncertainties underlying this estimate is the pace at which federal outlays and revenues would change after the law takes effect, we present the estimated fiscal impact as if the bill were fully implemented. Thus, workers in small firms, which would be phased in over five years, are treated as if they were already fully covered. Also, the estimate assumes that abrupt shifts in outlays and revenues, that may occur in the first year or two of implementation, are no longer singificant. If the bill is enacted during calendar year 1988, it would take effect on January 1, 1990. In such an event, CBO believes that S. 1265 would have no significant effects on the federal budget during fiscal year 1989.

The CBO estimate is, however, highly uncertain. Because the bill would have broad consequences, quantifying the costs requires the use of many assumptions. To illustrate the significance of the assumptions, we have provided a sensitivity illustration with high and low variants bracketing the CBO estimate. It is achieved by using two values for one key assumption on the outlay side and for one key assumption on the revenue side. The outlay sensitivity illustration shows the results of assuming that secondary payer enforcement realizes only 90% (high variant) and 100% (low variant) of what is estimated would be avoided when private insurers become primary payers for current federal beneficiaries. The revenue sensitivity illustration shows the effects of assuming that 100% (high variant) and 90% (low variant) of the new employer-paid premiums are paid for by reducing taxable wages (the remaining 10% being paid for by reducing existing non-taxed benefits). Although CBO believes the true value of these two variables lies within the assumed ranges, there is little evidence to support precise figures for either. We arrived at the CBO estimate for the variable by selecting the mid-points of each range. The purpose of the sensitivity analysis is to demonstrate the effects of substituting different assumptions on CBO's estimate. Of course, there are other assumptions, as discussed later, that could be varied to further demonstrate sensitivity. If these other assumptions were also varied, the range of uncertainty would be larger than that shown here. The estimate and two variants are as follows:

ANNUAL FEDERAL FISCAL IMPACT OF S. 1265

[Billions of 1990 dollars]

Budget category	Estimated effects on budget deficit		
	High variant	CBO estimate	Low variant
Revenue loss	6.2	5.9	5.6
Outlays	−5.1	−5.4	−5.7
Medicare	−3.5	−3.7	−3.9
Medicaid	−1.1	−1.2	−1.2
CHAMPUS	−.7	−.7	−.8
FEHBP	.2	.2	.2
Net change in the Federal deficit	1.1	.5	−.1

An important contributing factor making average estimated revenue reductions higher than average estimated outlay reductions is the mental health benefit, which was added to the bill shortly before the Committee vote. In itself, this additional benefit would increase the deficit by about $250 million dollars per year. Reduced federal outlays for mental health would be about $100 million per year, while reduced revenue would total over $300 million.

What follows is a general discussion of the methodology and magnitudes, as well as the uncertainties, involved in the estimate.

Basis for the estimate: In keeping with the CBO's general practices, the quantitative estimates are static—that is, they consider only the direct changes in behavior that would result from requiring health coverage for workers and their immediate families. Any indirect and secondary effects of the proposed law are not included in the estimates. According to this criterion, S. 1265 would change outlays for federal health programs either because current beneficiaries would receive primary coverage through the required employment-based insurance (and, hence, the federal government would become secondary payer) or because the federal government, as employer, would itself be required to insure those of its workers currently without coverage. There are about 6.7 million uninsured workers currently working and receiving federal health benefits who would switch to private insurance coverage if the law passed. About 0.8 million federal workers would gain health benefits coverage. On the revenue side, the proposed bill would cause federal tax receipts to drop because, it is assumed, otherwise taxable wages would be largely transformed into non-taxable health benefits—with total compensation remaining virtually unchanged.

Spending: S. 1265 would cause net reductions in federal outlays totalling about $5 billion. Each of four federal health programs would be affected: Medicare, Medicaid, the Civilian Health and

Medical Program for the Uniformed Services (CHAMPUS), and the Federal Employees Health Benefits Program (FEHBP). Except for outlays for FEHBP, outlays for each would fall. The estimates also assume that all workers would participate in employment-based plans (including all qualified federal employees), as mandated in S. 1265, even though their share of the employment-based premium might purchase few or no additional benefits for many of them.

Medicare would save about $4 billion, because employment-based plans would become the primary payers for essentially all beneficiaries employed at least 17.5 hours per week. Because most of these beneficiaries would not continue Part B coverage, about $400 million in reduced receipts of Part B premiums are accounted for in these estimated Medicare savings.

Private plans would also become the primary insurers for uninsured workers now enrolled in Medicaid, as they would for uninsured workers now covered by CHAMPUS. This secondary payer status for Medicaid would yield federal savings of more than $1 billion, and for CHAMPUS would yield federal savings of a little less than $1 billion.

Federal employees currently without FEHBP coverage would be required by S. 1265 to be covered under FEHBP, at a cost of about $400 million. Most of these employees are currently covered by the insurance policy of a working spouse. At the same time, some savings would be realized because working spouses of those federal employees who have chosen family coverage in FEHBP would not be required to take primary coverage through their own jobs. The net federal cost for FEHBP coverage changes would amount to about $200 million.

Revenue: Under the assmption that wages and salaries would drop by nearly all of the employer's share of the cost of providing new health insurance, federal revenues would fall by about $6 billion. About two-fifths of this drop would be due to lower income tax collections and about three-fifths of it would be due to lower payroll tax revenues (Social Security and Medicare taxes).

These revenue losses result from the differential treatment of wages and salaries—which are taxable—and of employers' contributions for employees' health benefits—which are not subject to either income or payroll taxes. Corporate tax revenues would not drop because we assume that, over the long term, all of the incremental costs of the mandated health benefits are paid for out of labor compensation, not out of profits.

Uncertainties in the estimate: Estimating the costs of S. 1265 to the federal government is an usually complex and uncertain task. Because the bill would have broad consequences, quantifying the costs requires the use of a large number of assumptions, many of which are uncertain. Three characteristics of our estimation of the bill's impact would tend to magnify any uncertainty due to the assumptions used.

First, because the net effect on the budget deficit is the difference between two large numbers, relatively small errors in estimating each could be magnified in the final number.

Second, the estimate of changes in outlays is uncertain because it consists of the sum of five separate and largely independent estimates—estimates of changes in receipts of Medicare's Part B premium and estimates of outlay changes in each of the four major federal health programs. Each of these five estimates is a large magnitude in itself; three of them represent contractions of federal costs and two represent expansions of federal costs.

Third, the estimate is uncertain to the degree that the behavioral responses of employees and employers to the implementation of S. 1265 are uncertain. While this estimate assumes that the total amount of labor compensation remains virtually unchanged after S. 1265 takes effect (with cash wages reduced by almost the full level of new health benefits), actual behavior—and the impact on revenues—might be different.

Costs to state and local governments: The budgetary effects on state and local governments would include both outlay and revenue effects. On the outlay side, for the states, reduced costs for Medicaid would be offset by decreased income tax receipts and increased costs of providing minimum benefits to currently uninsured state and local government employees. The estimated savings in Medicaid costs would be about $1 billion. The estimated new outlays required for state and local government employees would be about $800 million.

On the revenue side, the assumed reduction in wages would lower state and local taxes, but the magnitude is impossible to estimate. Local governments would gain from a reduced liability to pay for uncompensated care in city and county hospitals. The extent of these savings would depend on how local governments respond to the perceived effects of S. 1265 on local hospital budgets.

If you need further information or have any questions about this estimate, please call me or have your staff contact Alan Fairbank (226-2820).

Sincerely,

JAMES L. BLUM,
Acting Director.

VII. REGULATORY IMPACT STATEMENT

In accordance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the following statement of the regulatory impact of S. 1265 is made:

A. Estimated number of individuals and businesses who would be regulated and their groups and classifications

It is estimated that, at full implementation, S. 1265 would regulate most businesses with one or more employees and their employees—approximately 5.7 million businesses, 0.8 million farms and 95 million employees. Those not regulated would be owner-operated businesses with no employees.

B. Economic impact on the individuals, consumers, and businesses affected

The credible estimates supplied the Committee indicated negligible impact on employment as a result of enactment of the bill—between a .1 percent increase on the unemployment rate by the end of the third year in estimates not taking into account offsetting employment in the health sector and no net impact on unemployment in estimates taking into account such offsetting employment increases. The gross cost required to be assumed by businesses not currently insuring their workers and required to insure them as a result of enactment of the bill would be an estimated $1,146 per worker per year if care is provided through a cost-effective managed care plan; of this amount, 80 percent ($917) would normally be paid by the business and twenty percent ($229) would be paid by the employee. The net cost would depend on the situation of the particular business, since economic conditions will affect the degree to which additional costs are passed on to consumers or absorbed by the business in the form of lower profits. Businesses currently insuring their workers will experience reduced health care costs as a result of being relieved of the burden of subsidizing charity and unreimbursed care for other firms' employees. Currently uninsured and underinsured workers and their dependents will be protected against excessive out-of-pocket health care costs as a result of the insurance protection required by the legislation, and individuals eligible for employment-based insurance who currently purchase individual coverage will typically see their premium obligation reduced.

C. Impact of the Act on personal privacy

This legislation will not reduce personal privacy. It will enhance personal privacy for some employees currently required to reveal health status as a condition of receiving employment-based insurance.

D. Additional paperwork, time and costs

The legislation will result in some additional paperwork, time and costs for the Department of Health and Human Services, which is given the responsibility for implementing the law. Businesses may experience some additional record-keeping requirements to demonstrate compliance with the requirements of the legislation, but the time and costs associated with those requriements will depend on regulations promulgated by HHS to implement the act. Businesses will also experience reductions in regulatory requirements as the result of Federal pre-emption of state mandated benefit laws.

VIII. SECTION-BY-SECTION ANALYSIS

Section 1. Short Title, Table of Contents

The provision specifies that the Act may be cited as the "Minimum Health Benefits for all Workers Act of 1988." Also included is a Table of Contents for the Act.

Title I. Amendments to the Public Health Service Act

Section 101. Minimum health benefits for employees and their families. Section 101 would add a new Title XXIII to the Public Health Service Act providing for minimum health benefits for employees and their families. Under this new title, each employer would be required to enroll each of its employees and their families in a health benefit plan that meets the requirements specified in title III of the bill. If an employer which is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision, does not enroll each of its employees and their families in a health benefit plan, then it will not be eligible to receive a Public Health Service grant, contract, loan or loan guarantee. Any other employer which does not enroll each of its employees and their families in a plan would be subject to civil and other penalties, as specified in section 332 of the bill. Section 101 also provides that the terms of this section have the meanings as defined in section 303 of the bill, and that specified sections of the Public Health Service Act are redesignated for conforming purposes.

Title II. Amendments to Fair Labor Standards Act of 1938 and Employee Retirement Income Security Act of 1974

Section 201. Minimum health benefits for employees and their families. The section adds a new title II to the Fair Labor Standards Act of 1938 requiring that each employer enroll each of its employees and their families in a health benefit plan. The section provides that any employer that fails to enroll its employees and their families in a health benefit plan (as specified in this legislation) shall be subject to penalties, as specified in section 332 of the bill. Section 201 also provides that the terms of this section have the meanings as defined in section 303 of the bill, and provides for conforming changes in the Fair Labor Standards Act.

Section 202. Preemption under the Employee Retirement Income Security Act (ERISA) of 1974. Section 202 amends ERISA to provide that Federal law shall supersede (preempt) any State law that regulates or makes any requirements relating to contracts or policies of insurance issued to or under a health benefit plan under this bill, except that a state may continue to regulate the financial stability of an insurer.

Title III. Requirements for Health Benefit Plans for Employees and their Families

PART A. REQUIREMENTS AND DEFINITIONS

Section 301. Employer requirement to enroll employees in health benefit plans. Section 301 specifies that an employer may meet the requirement of the bill that it enroll each employee and the employee's family in a health benefit plan by enrolling them in any health benefit plan except that in the following cases, the employer must meet the requirement through a health benefit plan of a regional insurer (defined in section 323): (1) employers that do not have a health benefit plan on the day before the effective date of the bill (January 1 of the second year after the date of enactment); and (2) each small employer (an employer which employs an average of less than 25 employees during a calendar year) that does have in effect a health benefit plan on the day before the effective date, but changes the insurer through which the plan is offered or changes the plan from a self-insured plan to a plan of an insurer. Section 301 further provides that if the employer meets the requirement through a health benefit plan of a regional insurer, the employer must continue to meet the requirement through such a plan. However, a large employer (which was a large employer on the day before the effective date) which meets the requirement of the bill through a regional insurer plan may elect to meet the requirement through a plan other than that of a regional insurer. If such an election is made the large employer would no longer be able to meet the requirement through a regional insurer plan, so long as the employer remains a large employer.

Section 302. Coverage of family members. Section 302 provides that enrollment of an employee in a health benefit plan includes enrollment of the employee's family in the plan. An employee or the employee's family may not waive enrollment. Exceptions to the mandatory enrollment requirement include: (1) at the employee's option, the employee may waive enrollment for the spouse or child for such periods as the employee demonstrated that the spouse or child is actually covered under another employer's plan; (2) a child who is employed may waive enrollment in a plan provided by the child's employer during any period in which the child is covered due to employment of the child's parent. Section 302 also provides that an employer may not fail or refuse to hire, or may not discharge or otherwise discriminate against, any individual because the individual has a spouse or child and such employer is required under this bill to enroll the spouse or child in a health benefit plan.

Section 303. Definitions. Section 303 defines a number of terms used in the legislation, including the following: (1) a "child" means an individual who is under 18, or under 23 and a full-time student; (2) an "employee" means, with respect to an employer, an individual who performs 17.5 hours of service per week for that employer; (3) "employer" means, with respect to a calendar quarter, an employer which is required to pay the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938, or would be required to pay the minimum wage except for certain exemptions contained in the Fair Labor Standards Act, and any State or political subdivision thereof, or any agency or intrumentality of a State or political subdivision; (4) family and "family member" means the spouse and children of the employee; and (5) health benefit plans means a group health plan which (with certain exceptions) meets the requirements of section 311 of this bill. Section 303 also defines certain categories of employees and employers provided special treatment under the bill, including certain employees of temporary help service firms and employees of family farms.

PART B. REQUIREMENTS FOR HEALTH BENEFIT PLANS

Section 311. General requirements; permitting actuarially equivalent plans. Section 311 provides that in order for a health benefit plan to meet the requirements of this bill, the plan must satisfy certain requirements relating to benefits for items and services, coverage of employees and families, and the payment of premiums, deductibles, copayments, coinsurance and out-of-pocket limits. These requirements are specified in sections 312 through 314 as described below. A health benefit plan may also meet the requirements of this bill, notwithstanding that it fails to meet the specified cost-sharing provisions, if the actuarial benefits under the plan are not less than the actuarial benefits which would have applied if the plan met the specified requirements. The allowance for actuarial equivalency does not extend to the benefit requirement for prenatal care and well-baby care. It also does not extend to the requirements relating to timing of coverage and the prohibition of preexisting condition limitations (as specified in section 313). Section 311 defines "actuarial benefits" as the amount by which the total of the amounts payable as benefits under the plan exceed the amount of the premiums, deductibles, copayments and coinsurance payable by the employee under the plan, as determined on an actuarial basis per employee for a plan year. An advisory board to assist the Secretary on issues related to actuarial equivalency is established and it is specified that an employer that establishes actuarial equivalency according to good-faith procedures shall be deemed in compliance unless the Secretary affirmatively finds otherwise.

Section 312. Requirements relating to covered items and services. Section 312 specifies that a health benefit plan must include payment for (1) inpatient and outpatient hospital care; (2) inpatient and outpatient physician services; (3) diagnostic and screening tests; (4) prenatal and well-baby care; and (5) treatment for mental disorders. The bill does not require a health benefit plan to include payment for (1) items and services that are not medically necessary; (2) routine physical examinations or preventive care; or (3) experimental services and procedures. The section requires that the Secretary of HHS, by regulation, prescribe, and annually revise, a schedule specifying the amount, duration and scope of prenatal and well-baby care to be included in a health benefit plan. Section 312 specifies that managed care systems may be used to deliver covered services, that the basis of payment for covered services may differ from actual charges, and that new, small businesses may provide only catastrophic coverage.

Section 313. Requirements relating to timing of coverage and prohibition of preexisting conditions limitations. Section 313 requires that coverage under an employer's health plan begin no later than the latest of the following: (1) 30 days after the day on which the employee first performs an hour of services as an employee of that employer; (2) the first day on which the employer is required to meet the requirements of this bill; (3) in the case of a health benefit plan which has been provided by an employer since May 19, 1985, and is provided by an employer which provides interim coverage (as defined below), the earlier of 6 months after the day on which the employee first performs an hour of service as an employee of the employer, or the date for initiation of coverage under the plan (as in effect on May 19, 1987). Interim coverage is defined as a plan that would meet the requirements of section 311 except that (1) the interim plan requires a premium that on a monthly basis exceeds the premium otherwise permitted under the bill (see section 314), so long as the premium on a monthly basis does not exceed the monthly actuarial rate (as defined below in section 314); or (2) the interim plan requires deductibles and coinsurance that exceed permitted amounts under the bill, so long as the interim plan meets the specified requirement relating to limitations on out-of-pocket expenses. Section 313 also prohibits a health benefit plan for excluding or otherwise limiting any individual from coverage under the plan on the basis that the individual has (or at any time has had) any disease, disorder or condition. Section 313 provides that certain plans—those described in Section 3(37) of the Employee Retirement Insurance Act—may establish alternative waiting periods, and that special rules apply to temporary help employers.

Section 314. Requirements relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses. Section 314 provides that a health benefit plan may require an enrollee to pay for premiums, deductibles and coinsurance amounts for coverage under the plan, but only if those payments do not exceed the following limits.

(A) *Premiums.*—(1) A plan may not require an employee to pay a premium for coverage for a period longer than 1 month, or the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate. The monthly actuarial rate is defined as the average monthly per enrollee amount which the employer providing the plan estimates, for enrollees under the plan during the year, would be necessary to pay for the total benefits required under the plan (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year. A health benefits plan may provide for the premium to be applied, and the monthly actuarial rate to be computed separately for employees with and without a family. It may also provide for separate calculations of the premiums for employees with a spouse and children, for employees who have a spouse but no children and for employees who do not have a spouse but have children. (2) The bill prohibits a plan from requiring a premium for an employee whose hourly wage rate in 1988 is less than $4.19, or for a subsequent year, is $4.19 increased by the percentage increase in the CPI for all urban consumers for the 12-month period ending on September 30 of the preceding year. (3) An employee enrolled under a health benefits plan is liable for the payment of the required premiums. All requirements may be modified and subject to the actuarial equivalency test. Employers are required to establish a separate premium category for employees selecting family plan coverage in which the family has two working spouses. The employee's share of the premium may be modified subject to the actual equivalency test.

(B) *Deductibles.*—The bill limits the deductible to $250 for an individual or $500 for a family, but prohibits a plan from imposing a deductible for prenatal or well-baby care. These amounts are indexed the C.P.I. for urban consumers. The bill specifies that a plan may provide for a wage related deductible amount so long as the amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year for individual coverage and 2 percent of the total wages paid to the employee in the plan year for family coverage. These requirements, except for the requirement relating to prenatal and well-baby care, may be modified subject to the actuarial equivalency test.

(C) *Copayments and coinsurance.*—The bill prohibits a plan from requiring: a copayment that exceeds 20 percent of the cost of the item or service; any copayment or coinsurance for prenatal care or well-baby care; and a copayment for items and services required under the bill furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan equal to the out-of-pocket limit. The bill provides for exceptions to the above requirement relating to the payment of copayments and coinsurance for items and services furnished by nonparticipating providers under preferred provider arrangements, and in cases where the individual has obtained an item or service without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services. The requirement that copayments above 20 percent may not be required may be modified subject to the actuarial equivalency test.

(D) *Out-of-pocket expenses.*—The provision defines out-of-pocket expenses with respect to an employee in a plan year as amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and family covered under the plan. The provision defines the out-of-pocket limit to mean $3,000 for the plan year beginning 1 year after the date of enactment of this bill, or for subsequent years, $3,000 increased by the increase in the CPI for all urban consumers for the 12-month period ending on September 30 of the preceding calendar year. A health benefit plan may provide for a wage-related out-of-pocket limit if the limit for the employee and the employee's family does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year. The out-of-pocket limit may be modified subject to the actuarial equivalency test.

PART C. CERTIFICATION OF REGIONAL INSURERS

Section 321. Designation of health insurance regions. Section 321 requires the Secretary of HHS to designate by regulation 6, 7 or 8 health insurance regions.

Section 322. Periodic certification of regional insurers. Section 322 requires the Secretary of HHS to establish procedures for the periodic certification of regional insurers for each health insurance region for a defined period. No insurer may be certified as a regional insurer unless it meets standards of financial stability established by the Secretary; agrees to enroll any group eligible to enroll with a regional insurer; agrees to offer only plans and plan options approved by the Secretary; agrees that if it offers a managed care program to any organization within the region, it will also make this managed care package available in this capacity as regional insurer; and agrees to allow offerings to be described in a phamplet distributed by the Secretary and to enroll applicants by mail. No insurer may be certified as a regional insurer unless it submits to the Secretary an application for certification in such form and at such time as the Secretary prescribes. The application must include specific descriptions of each of the health benefit plans that the insurer proposes to offer and the information needed for the Secretary to consider the following: (1) the price of the health benefit plans proposed to be offered by the applicant, (2) the quality and types of services to be provided under the plans; (3) the experience of the applicant in providing and managing health benefit plans; and (4) the financial stability of the applicant. Section 322 further provides that not later than 1 year after the date of enactment of the bill, the Secretary is required to certify regional insurers for each health insurance region, and to publish a list of the certified regional insurers in the Federal Register. The Secretary is also required to periodically evaluate the performance of regional insurers. Where the Secretary finds that a regional insurer is not substantially meeting requirements, the Secretary, after notice and opportunity for a hearing, may terminate the certification of the insurer.

Section 323. Requirements of regional insurers. Section 323 requires each regional insurer to offer to employers located in its health insurance region at least two indemnity plans, one of which provides only the minimum health benefits required of a health benefit plan, and the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region; or two managed care plans, one of which provides only the minimum benefits required of a health benefit plan, and the other of which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region. In either case, the regional insurer may provide optional, additional benefits for an additional premium. Section 323 describes an indemnity plan as one which makes payment with respect to items and services furnished by any provider licensed in the State to provide the items and services (and meets certain other specified conditions); and under which the individual incurs an obligation or makes payment for a covered item or service and the plan reimburses the individual or the provider of such services for the amounts payable for such item or service under the plan. Section 323 describes a managed-care plan as a plan under which item or services must generally be furnished either by providers having a contractual relationship with the plan, or providers included on a list specified by the plan which consists of a group of providers in a State which is more restricted than all licensed providers in the State. Section 323 further provides that each regional insurer fix premiums for the plans under a community rating system for all employers. It prohibits an insurer from adjusting such premiums based on the age or gender of employees (or their families) or on other factors relating to the projected or actual use of health services under the plan.

Section 324. Miscellaneous provisions. Section 324: (1) provides that each regional insurer may enter into subcontracts with other entities; (2) requires the Secretary to encourage regional insurers to enter into appropriate arrangements with entities representing groups of small businesses (such as small business service bureaus and chambers of commerce) for the provision of administrative services with respect to small businesses enrolled in plans offered by the insurers; (3) requires each such regional insurer to reduce the premiums otherwise charged for such plans to such small businesses by an amount which reflects the value of such administrative services; (4) requires the Secretary to provide technical assistance and enrollment forms to employers required to provide health benefit plans through regional insurers. Requires the Secretary, to the maximum extent feasible, to enter into contracts with small business service bureaus, chambers of commerce, and other entities with experience in providing health insurance services to small businesses.

PART D. REGULATIONS AND ENFORCEMENT

Section 331. Regulations. Section 331 provides that the Secretary of HHS must publish a notice of proposed rule making to carry out this legislation within 4 months after enactment. It requires the Secretary to promulgate final rules within 9 months after that date.

Section 332. Enforcement. Section 332 provides for enforcement of the provisions of the bill. It provides for a civil money penalty of not more than 10 percent of the total amount of the employer's expenditures for wages for employees in that year for any non-governmental employer which does not comply with the requirements that it provide its employees a minimum health benefit plan. The penalty shall be assessed by the Secretary of HHS and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity to present its views on the charge. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer in attempting to achieve rapid compliance after notification of noncompliance by the Secretary. In any civil action brought to review the assessment of such a penalty or to collect the penalty, the court shall, at the request of any party to such action, hold a new trial on the assessment of the penalty, unless in a prior action such a trail was held on the assessment. Section 332 further provides that any nongovernmental employer that knowingly fails to comply with the requirements of the bill shall be liable for damages (including health care costs incurred) to the employee or the employee's family resulting from a failure to comply. Section 332 also refers to section 2301(b)(1) of the Public Health Service Act, for making States and their political subdivisions ineligible for public health service funds if they fail to enroll employees under health benefit plans. The section further provides that any individual injured or adversely affected or aggrieved by a violation of the requriements of this bill may bring an action in an appropriate district court of the United States to enjoin such a violation or to compel compliance with the specified requirements. It provides for the payment of reasonable attorney's fees as part of costs if the party substantially prevails, and requires notice to be sent to the Secretary of HHS and the Attorney General 15 days before a party brings action for injunctive relief. The notice must state the nature of the alleged violation and the court in which the action will be brought.

Title IV. Effective Date

Section 401. Effective date. Section 401 provides taht the bill, and the amendments made by the bill, shall take effect on January 1 of the second year that begins after the date of enactment. In the case of an employer which, on the date of enactment has in effect a health beneift plan, the bill shall not apply until the first day of the second plan year that begins after the date of enactment. In the case of state and local governments, the effective date is the first day of the third plan year beginning after enactment. In the case of small businesses of five employees or less, coverage is phased in over a five year period.

Section 402. Policy respecting additional benefits. Section 402 provides that after the bill is enacted, no employer will be required to provide any health benefit in addition to those specified under the relevant sections of the bill unless the additional benefit is for a service which State Medicaid plans are required to cover for individuals receiving cash assistance under title IV of the Social Security Act, and the benefits and costs of requiring the provision of the additional benefit have been analyzed and considered by Congress. In such a case, the Congress shall request a report from the Office of Technology Assessment, the Institute of Medicine of the National Academy of Sciences, or a public or nonprofit entity with expertise relating to health benefits. The report shall analyze and summarize each proposed additional health benefit and contain an estimate of its economic and health impacts. The report shall be prepared in consultation with interested members of the public and with individuals having expertise with respect to the proposed benefit.

IX. Committee Views

The Committee concludes that S. 1265 would be an effective solution to the problems of uninsured and underinsured full-time workers and dependents of workers. According to testimony of the Congressional Budget Office, enactment of S. 1265 would result in health insurance coverage for 23 million workers and dependents currently without any health insurance coverage. An additional 18 million employees or dependents of employees who now buy individual insurance—typically at relatively high cost and relatively low value—would be able to replace individual insurance with more cost-effective employment-based coverage. More than 50 million workers and dependents without catastrophic stop-loss coverage would be provided it, and approximately 1.9 million families that experience catastrophic out-of-pocket health care costs each year in excess of $3,000 would be protected.

In addition to providing health insurance protection to millions of workers and their families, S. 1265 would benefit particular groups. More than seven million currently uninsured children would gain health insurance coverage. This figure includes health insurance coverage for 300,000 disabled children. Seven million currently insured but medically uninsurable individuals would be guaranteed insurance coverage if they change jobs. Four hundred thousand uninsured pregnant women annually would be guaranteed coverage for pre-natal care, delivery, and well-baby care. Welfare families would be assured that they would not lose health insurance coverage if the family head were to get a job.

While some small businesses, as well as other businesses, would experience increased costs as the result of enactment of S. 1265, the Committee felt that the principle of requiring each employer to insure its own workers would result in reduced costs for the majority of businesses that do provide health insurance coverage and would promote economic efficiency by establishing a level competitive playing field. Small businesses, in particular, would benefit by the opportunity to purchase health insurance coverage for their workers at a more competitive price and by guaranteed availability of coverage. These cost reductions and the opportunity to compete more effectively for labor through providing high quality health insurance would, in the Committee's view, be of significant benefit to the small business sector of the economy.

In approving S. 1265, the Committee carefully considered and rejected a number of concerns expressed by opponents of the bill. These included:

Fears that the bill would result in significant unemployment and economic dislocation;

Contentions that the cost of coverage would be too burdensome for small business;

Claims that the cost of the bill were significantly understated;

Concern that enactment of the bill would adversely affect international competitiveness;

Arguments that enactment of the bill would set off a new round of health care cost inflation;

Opposition to any employment mandates as interferences with the free market; and

Suggestions that alternative approaches would be equally successful and less burdensome

UNEMPLOYMENT AND ECONOMIC DISLOCATION

The economic impact of the bill was analyzed by Professor Karen Davis, who presented the results of an analysis of the effect of the bill using the Data Resources, Incorporated, model of the U.S. economy; by Professor F. Gerard Adams, using the Wharton Econometric model, and by the Congressional Budget Office. Professor Davis reported that the DRI model estimated an increase in the unemployment rate of one-tenth of one percent by the end of a three year period, equivalent to the net loss of 100,000 to 120,000 jobs. Professor Davis analyzed the DRI model estimate and stated that, because the model did not take into account offsetting employment increases in the health sector, there would be no net job loss as the result of enactment of the bill. Professor Adams reported that the Wharton Economic model projected no net job loss at the end of a two year period. The CBO estimated job loss at between 50,000 and 100,000 jobs, without taking into account any expanded employment in the health sector.

Based on these estimates, the Committee concluded that if any job loss did occur as a result of the legislation, it would be a very minor consequence in an economy that has created more than 13 million jobs over a three and one-half year period, and any job loss that did occur could be easily offset by other economic policies. The Committee noted that, in February, 1988, alone, more than five times as many jobs as MHB might hypothetically cause to be lost were created by the normal working of the economy. Moreover, the Committee concluded that there was not other practical policy or mix of policies that would achieve the goal of access to essential health care and health insurance for all working Americans with so little negative economic impact.

BURDEN ON SMALL BUSINESS

The Committee was concerned about the potential burden on small businesses, which are disproportionately likely not to insure their workers, that might be created by the requirement for provision of health insurance coverage. The Committee also recognized, however, that the majority of workers who are employed by small businesses of 25 employees of less work for employers that do offer health insurance coverage. The Committee was also aware that small employers who voluntarily offer health insurance coverage to their workers face considerable disadvantages in the current health insurance market. First, they face a cost disadvantage against competitors, large and small, that do not provide this essential benefit to their employees. Second, small employers of 25 workers or less must pay 20 percent more, on average, for the coverage they buy than their larger competitors pay for identical policies. For very small employers, of ten employees or less, the cost disadvantage can mount to 30 to 40 percent. Finally, the practice of medical underwriting and concern about adverse selection that many insurance companies express often makes insurance unavailable to small employers at any price. These characteristics of the current health insurance market make it very difficult for small businesses to offer the kind of health insurance all employees need at a reasonable price and makes it more difficult for them to be price competitive and to attract a capable labor force. Indeed, when these features of the small business health insurance market are taken into account, the fact that a majority of small business employees work for firms that provide health insurance is far more impressive than the fact that a disproportionate number of small business employees are not provided coverage.

Because of these factors, the Committee concluded that a properly structured mandatory insurance system might improve the economic status of small businesses generally, even though some small businesses would experience some increased costs. The regional insurer structure created by the S. 1265 will reduce premium costs to small businesses by an estimated 10 percent as a result of savings on sales and administrative costs; more widespread availability of managed care alternatives under the bill would make savings of an additional 15 percent possible. The legislation also assures availability of coverage to all small businesses and guarantees that no employee would be excluded from coverage of subjected to coverage limitations or exclusions based on health status.

It is important to recognize that most of these benefits to small business can only be achieved in the context of mandatory coverage. Without mandatory coverage, it is difficult to avoid the "churning" in the market that contributes to high sales and administrative costs; it is impossible to avoid the adverse selection problems that result in medical underwriting and preexisting condition exclusions; and it is not feasible to community-rate coverage.

In addition to these benefits to small business, the benefit package required to be offered by businesses large and small under S. 1265 has been carefully crafted to be an affordable one. While providing good basic coverage to all workers and their families, the benefit package required to be offered under the legislation is a low cost plan that is significantly less elaborate than most employment-based insurance offered today. According to estimates supplied by the Actuarial Research Corporation to the Committee and to CBO, the cost an employer must pay if he purchases the required coverage through a managed care health insurance provider will average about $917 per worker per year. This works out to a salary cost of about 46 cents per hour for a full-time worker. This is equivalent to less than a fifteen percent increase in the minimum wage and, in the judgment of the Committee, will not present a major problem for most businesses.

A number of authorities, as noted above, examined the impact of MHB on overall employment. They found that the impact would be negligible. Since small businesses have been the major source of job creation in the U.S. economy in this decade, predictions of serious economic damage to small business as a result of MHB are inconsistent with these estimates.

Finally, it is important to note that those who contend that the problem of the uninsured worker is primarily a problem for small businesses are mistaken. While small businesses are disproportionately likely not to insure their workers, a majority of uninsured workers, according to the CBO's analysis of census data, work for employers with more than 25 employees. Almost one quarter of uninsured workers are employed by businesses with more than 1,000 employees.

UNDERSTATEMENT OF COSTS

Opponents of the legislation claimed that the estimates by the Congressional Budget Office and by the Actuarial Research Corporation of the total cost of the legislation and of the premiums required to purchase the minimum health plan were too low. Several studies producing alternative cost estimates have been cited. The Committee has carefully considered these alternative studies, and, based on the reviews of independent experts, found them to be incorrect in their methodology and conclusions.

One of these studies was presented to the Committee in testimony at its November 4, 1987, hearing. It was commissioned by the Institute for Research on Economics and Taxation and carried out by Gary Robbins, a consultant. Robbins claimed MHB would cost $100 billion, four times as much as the CBO estimate. As CBO pointed out in its testimony at the hearing, the Robbins study made four errors. First, it overestimated the premium cost by $12 billion by assuming MHB would cost as much as an "average" employment-based plan. In fact, the benefits required under MHB are significantly less generous than the average employment-based plan provides today. For example, according to Labor Department and Small Business Administration data:

Ninety-seven percent of insured workers are covered for prescription drug costs. MHB does not require drug coverage;

Seventy percent of workers are covered by plans that provide coverage in an extended care facility, but MHB does not require such coverage;

Sixty percent are covered for home health care expenses, but MHB does not require such coverage;

Seventy-one percent are covered for dental care, but MHB does not require such coverage;

Seventy-four percent of workers are covered by plans with a deductible of less than $200 and 58% are covered by plans with a deductible of $100 or less. By contrast, MHB requires a deductible of $250. Lowering deductibles has a very significant impact on cost; and

Seventy percent have catastrophic stop-loss coverage of $2,000 or less, compared to the requirement in MHB of catastrophic stop-loss coverage of $3,000.

Second, the study assumed that there would be $45 billion in costs from duplicate coverage of employees in the same family working for different employers. As CBO and Professor Karen Davis noted in separate analyses of the Robbins study, this estimate ignores the universal insurance company practice of coordination of benefits to avoid duplicate payments for overlapping coverage. These authorities concluded that there would be *no* additional cost from duplicate coverage, and even the author of the study admitted that any duplicate coverage costs would disappear after a few years.

Third, the study assumed upgrades in existing plans would cost $16.3 billion. CBO pointed out that an estimate like this ignores the actuarial equivalency rules of MHB, which allow employers not to meet many of the specific standards of the minimum plan, as long as their plan is of greater or equal total value. This mstake is also made by a number of privately conducted surveys of firms, which report that many would have to upgrade their existing plans. These surveys ask employers if they meet the minimum requirements of S. 1265, but they do not inform responding employers that these minimum requirements may be modified by the actuarial equivalency test. CBO found that the cost of upgrading existing plans, taking into account the actuarial equivalency test, would be only 42 billion, an amount included in the CBO estimate.

Finally, the study assumed additional administrative costs of $2 billion. The CBO found these costs to be negligible.

A second study sometimes cited is by Robert R. Nathan Associates. This study found the cost of MHB to be approximately $10 billion higher than the CBO estimate. CBO and GAO were asked to analyze the accuracy of the methodology used in the Nathan study. Both found the study to have made serious methodological errors that resulted in an excessively high estimate of cost. Specifically, the Nathan study:

Assumed that MHB premium costs would approximate the average costs of current employer-based plans, despite the fact that MHB is significantly less generous than current plans;

> Failed to take into account the demographic characteristics of currently uncovered workers which result in significantly lower average costs for them than covered workers; and
>
> Used an indexing factor to project current costs to 1988 which was too high.

Finally, studies by individual insurance companies or the HIAA are sometimes cited in which the MHB benefit package is estimated by a company based on its own book of business. These estimates often produce premiums somewhat higher than those estimated for MHB by the Actuarial Research Corporation. Gordon Trapnell, President of Actuarial Research, listed the reasons why such estimates tend to be too high at the Labor Committee's November 4 hearing:

> The demographic characteristics of currently uninsured workers make them less costly to cover than currently insured workers. Analysis by the CBO indicated that currently uncovered workers are younger, more likely to be single, and more likely to be located in areas of the country with lower than average health care costs than currently covered workers. All of these factors lower the cost insurance, but insurance company estimates based on their current book of business do not reflect these differences;
>
> Average costs are reflected in the ARC estimates, rather than the costs of commercial insurance companies; these average costs include costs of Blue Cross plans that get substantial hospital discounts in some areas;
>
> Reduction in the cost-shift from employers who currently offer health insurance to those who do not as the result of the enactment of MHB are not taken into account; these cost-shifts are built into insurance company estimates but would disappear under MHB.

Another, related error sometimes made by opponents of the bill is to cite insurance premium increases in a particular year as representative of the increase in health care costs. In fact, insurance company premiums in any given year blend projections of costs in the following year with corrections for errors in estimates in prior years. Accordingly, they tend to overstate or understate actual cost increases, depending on the year.

INTERNATIONAL COMPETITIVENESS

Concern about the impact of MHB on the United States' ability to compete in international markets has been expressed by some. The Committee considered this question and concluded that enactment of S. 1265 would help, rather than hurt American businesses struggling to compete in international markets. Walter B. Maher, Director of Employee Benefits for the Chrysler Corporation, a company that faces strong competition from foreign automobile manufacturers, testified at the Committee's June 24, 1987, hearing on behalf of the bill. He stated, "One factor aggravating health care costs is that when so-called 'charity' care is provided to the uninsured in America, the cost is passed on to others in the form of higher health care charges to paying patients and higher premiums to firms that provide insurance. It also puts pressure on public health systems, which serves to increase taxes required to fund such systems. At Chrysler, we already pay handsomely to provide the health care coverage we do. Given the competition we face, it is unfair that a minority of employers, usually those not facing foreign competition, can effectively let someone else pick up the tab for their employees' health expenditures."

The Committee found that firms at the cutting edge of international competition almost universally insure their workers. According to an SBA study, ninety-seven per cent of workers in manufacturing are employed by companies that offer health insurance coverage. By contrast, the bulk of uninsured workers are employed in industries like retail sales, services, and construction that do not generally face foreign competition.

HEALTH INFLATION

Some opponents of the legislation contended that the demand for additional services stimulated by the bill would touch off an additional round of health inflation. Based on the testimony of expert witnesses and documents submitted for the record, the Committee concluded that this would not occur. The issue was examined by Professor Karen Davis, by the CBO, and by Professor F. Gerard Adams and they all concluded that the net increase in health care spending generated by MHB was so small relative to the total size of the health care industry and the existing overcapacity in the industry was so great, that no significant increase in inflation rates would result. Indeed, Professor Adams suggested that inflation rates might actually come down because the increased volume of services resulting from the bill might reduce pressure to raise charges to cover overhead or reach target incomes.

INTERFERENCE WITH THE FREE MARKET

At the Committee's November 4 hearing, Tom Moore, a member of the President's Council of Ecomonic Advisors, contended that a requirement that employers provide health insurance coverage to their workers was an unwarranted intrusion in the operations of the free market. The Committee concluded, however, that employer mandates were far from unprecedented. Our society already requires employers to participate in Social Security, in Medicare, in unemployment compensation and in workman's compensation. Employers are prohibited from hiring child labor or paying less than the minimum wage. The Committee believes that our society is richer, not poorer, for enacting these mandated benefits and regulations on the untrammeled operation of the free market.

When Mr. Moore was questioned about the Administration's position on these existing mandated benefits, he indicated that the Administration supported all of them.

ALTERNATIVE APPROACHES

While no amendments to provide an alternative method of assuring care for workers and dependents were offered at the Committee's mark-up of S. 1265, a number of alternatives have been suggested by the opponents of the legislation. They include: expansion of the Medicaid program, Federal preemption of State regulation of the content of employment-based health insurance, more favorable tax treatment of the owner-operators of unincorporated small business, and elimination of current regulatory barriers to the formation of multiemployer trusts. In reviewing these alternatives, the Committee found them to be unsatisfactory.

Medicaid expansions.—The Committee concluded that while Medicaid expansions are desirable, expansions of the scale necessary to cover all the currently uninsured are unrealistic. Based on the estimated cost of MHB, coverage of all the uninsured would add $33 billion annually in public spending, of which approximately $19 billion would be paid by the Federal Government and $14 billion would be paid by the states. As Professor Karen Davis pointed out in her testimony before the Committee, the highest priority for scarce public dollars should be granted to those who could not be reached by an employer mandate—individuals in families with no full-time worker.

In addition, proposals for making Medicaid the primary insurer of the low and moderate income working population raise serious questions of equity and impact on our current system of private, employment-based insurance. The private, employment-based system has served most workers and the American people well, but it would be fundamentally weakened if employers could easily shift the cost of insuring their workers to taxpayers simply by dropping coverage for their employees. Conversely, limiting the availability of Medicaid coverage to currently uninsured workers would be grossly unfair to employers who provide and pay for coverage for similar workers. And the cost of the Medicaid program would grow astronomically if Medicaid were the primary insurer not only of currently uninsured low income workers but of the majority of low-income workers who are already insured by their employers.

Federal pre-emption.—Enactment of legislation to eliminate state regulation of the content of health insurance is improbable except in the context of alternative Federal regulation. Moreover, no credible analysis was presented to the Committee establishing that the costs added by state mandates are significant enough to produce significantly expanded voluntary coverager if removed. Indeed, almost one-quarter of all uninsured workers are employed by firms with 1,000 or more employees, and these firms could easily self-insure and avoid state mandates if they wished. Finally, an integral feature of the MHB proposal is the Federal pre-emption of state mandates; to the degree that businesses would voluntarily insure their workers if state mandates were abolished, the Federal mandate continued in MHB will simply reinforce a decision that would be taken voluntarily.

More favorable tax treatment.—Currently, the owner-operators of unincorporated small businesses are treated unfairly by the tax laws. When a business pays the health insurance premiums of the hired manager of a large corporation, the cost of the premiums is not treated as taxable income to the employee. When the small businessman buys his own health insurance coverage through the group plan of his business, he is taxed on three-quarters of the cost of the premium.

This situation is inequitable and should be remedied, but to suggest that changing the tax laws to allow full deductibility will be a major incentive to expanded coverage of the employees of small business is not persuasive. For example, consider the case of an owner-operator of an unincorporated small business with five employees. Assume the owner is in the top marginal tax rate of 28%. Based on the average per-worker premium for the health insurance package required under S. 1265 and purchased through a managed system of care, the employer would be required to spend $5,731 to insure himself and his employees. His savings as a result of the proposed change in the tax laws would be $2,390 or approximately four percent of the additional costs he would be assuming.

Eliminate regulatory barriers to the growth of METs.—No persuasive evidence was presented to the Committee that current laws have significantly inhibited the growth of METs. Moreover, as the analysis earlier in the Committee report pointed out, METs are not sufficient to overcome many of the problems present in the small employers market: medical underwriting, high sales and administrative costs; and excessive churning in the market.

Hospital subsidies.—A related point sometimes made by opponents of the legislation is that it represents an excessively costly solution to the problem of uncompensated care provided by hospitals. The implication of this argument is that it would make more sense to subsidize the $8–10 billion in uncompensated care provided by hospitals directly than to incur the estimated $27 billion cost of MHB. The argument is faulty in several respects. First, the primary problem that needs to be solved is not the financial burdens placed on hospitals by the current system; it is the uninsured and underinsured's lack of access to essential health care and their vulnerability to financial disaster when they do get the care they need. Subsidizing hospital uncompensated care does little to address these problems. Under such a scheme, families would still suffer the financial diasters that uninsured illnesses bring. Uninsured and underinsured individuals would continue to face strong financial disincentives to seek needed care; and care would still only be available after the individual was so ill that he or she required hospitalization. Finally, a program of the kind of subsidies apparently envisioned in this approach would do nothing to correct the inequities in the current system. Through taxes or other mechanisms, businesses that currently insure their workers would continue to subsidize the medical costs of other businesses' uninsured employees.

An additional issue the Committee considered was a set of questions involving the regional insurance structure created by the legislation in order to reduce costs to small business. First, there was concern that the original plan design, which restricted the number of carriers to three to five per region, might have the unintended effect of reducing competition and would make it difficult for small and medium-sized insurers to continue to operate in the small employer market. The Committee responded to this concern by dropping the requirement that only three to five insurers could become regional insurers and allowing additional insurers to be certified as regional insurers if they met the requirements of the Act.

Concerns were also expressed that the requirement that regional insurers community-rate premiums on a region-wide basis could result in excessive cross-subsidization between high and low-cost states within a region. The Committee recognizes that cross-subsidization is inherent in any insurance program and is a desirable way of keeping premiums affordable for all participants. Thus, a large employer, in effect, community-rates its employees: all workers pay the same premium whether they are young or old, in good or in poor health, regardless of where they reside. Medicare community-rates its coverage: all senior citizens pay the same premium, whether they are 65 or 85, in good health or poor health, or resident in high or low cost areas of the country.

Failure to community-rate is a special problem for small businesses because there is no large pool of individuals across which to spread risks. Thus, any factor driving up costs for an individual can price insurance out of reach for the whole group.

In establishing community-rating on a region-wide basis, the Committee desired to keep insurance affordable for all small businesses and to provide the advantages of as large a pool of participants as possible within each regional insurance plan. The Committee recognizes, however, that wide interstate variations in costs between States within a region could result in excessive interstate cross-subsidization. At the same time, increasing excessively the number of areas within regions that could be used for community-rating purposes could increase administrative complexity and cost, could reduce the benefits of economies of sale, and could undercut the essential goal of affordability of coverage for all small businesses. Accordingly, the Committee intends to work with interested members and experts to design an amendment that will preserve the benefits of community-rating across a wide geographic area while assuring that there is no excessive transfer of funds between high and low cost states.

In addition to concerns about interstate cross-subsidization and the number of insurers allowed to become regional insurers, some have alleged that the regional insurance scheme would not produce savings in retention rates (administrative and sales costs), because the costs of serving many small units would still occur under the regional plan structure. It is true that, even under the regional insurer plan, it will continue to be more costly to serve the small employer than the large employer market. These continuing cost differentials were assumed in the estimates supplied the Committee by the Actuarial Research Corporation, which projected reductions in retention rate from an average of 25 percent to an average of 15 percent. Although this is well above the five percent retention rates typical of large businesses, it represents a savings of approximately 10 percent of total premium to small businesses. Savings in retention rates under the regional insurer program arise from elimination of the costs of medical underwriting, reduction in the frequent enrollment and disenrollment characteristic of the current small employer market, enhanced competition as the result of plan standardization, economies of scale, and the opportunity for less costly enrollment and disenrollment by mail. Moreover, small businesses could save an estimated additional fifteen percent of premium if they chose to participate in the cost-effective managed systems of care that will become available under the regional insurer structure.

The ability to achieve the projected savings in retention rates is demonstrated not only by the professional estimates of the Actuarial Research Corporation but by the experience under the Federal Employees Health Benefit Program (FEHB), which has some similarities to the regional plan structure. It should be noted that, while FEHB has many similarities to the regional plan system, it also has some differences which would tend to raise its administrative costs relative to the regional plans: enrollment is at the employee level rather than the firm level, and this promotes excessive shifting between health plans and multiplies the number of units that must be dealth with. Nonetheless, retention rates under FEHB are limited to eleven percent, well below even the retention rates projected under the regional plan structure.

While some opponents of the regioanl plan have conceded its similarity to FEHB, they have also alleged that some of the problems that have afflicted the FEHB would also be typical of the regional insurer program. These problems include excessive shifting between plans, plan choices that are confusing to consumers, and competition among plans to design benefit packages that attract good risks rather than competition to render care economically and efficiently. The Committee has carefully constructed the regional insurance program to avoid these problems. While a broad range of benefit choices is allowed and encouraged, benefit options must be standardized across insurers. Accordingly, insurers must compete primarily on the basis of price and service rather than being able to manipulate benefits to attract good risks. Plan standardization also promotes optimal choices by consumers, and plan switching is minimized by making the unit to which insurance is sold the firm rather than the individual employee.

Committee comments on specific sections of the legislation follow.

Section 210. Health benefits

This provision establishes a general requirement that all employers, except those specifically provided special treatment under other provisions of the bill, must enroll their employees in a health benefits plan meeting the standards of the act. Nothing is this bill shall be construed as relieving any employer of any obligation under a collective bargaining agreement, a multi-employer plan, federal employee benefits or labor law, except to the extent necessary to comply with the bill's provisions. Accordingly, for example, the bill shall not be construed as authorizing an employer to discontinue or reduce contributions or to change plans. The collective bargaining process, the plan rules, and existing law will continue to govern the employer's contribution obligations.

Section 302. Coverage of family members

The legislation is intended to assure health insurance coverage for both employees and dependents of employees. Accordingly, it is the obligation of the employer to provide coverage for both employees and all members of an employee's family. Since the legislation also establishes the principle that it is the obligation of an employer to provide primary health insurance coverage to his own employees, situations will arise in which a working spouse or the childen of two working spouses might be offered coverage by more than one employer. For example, a husband and wife who work for different employers would be offered coverage both for themselves and their dependents by each employer.

In this situation, the employees are not obligated to accept family coverage under both plans. Instead, the employees could choose to have each employer cover his own employee and put the children on one or the other plan. In such a situation, it is the obligation of the employee to demonstrate that his or her family is already covered under another plan. The Committee does not intend that the employer make extraordinary efforts to verify the accuracy of the employees demonstration, and it anticipates that regulations of the Secretary shall make clear that the obligation of the employer would not extend beyond such actions as requiring the employee to provide a certification from the other employer that the relevant family members are in fact covered or to provide a copy of the policy provided by the other employer along with documentation that the spouse or children are in fact covered under the other policy.

The Committee recognizes that employment situations may change over time, and an employed spouse may be discharged or resign employment. If such an event occurs, it shall be the obligation of the spouse that continues to have employment-based coverage to notify his employer that his coverage needs to be changed to a family plan policy.

In order to determine whether an employee has dependents that may be eligible for coverage under an employment-based plan, the Committee anticipates that the Secretary shall specify in regulations that the employer must inquire of his employees whether they have dependents, but does not anticipate that the employer would be required to verify the accuracy of the employee's statement, unless the employer has reason to believe that the employee's statement is false.

As specified in the legislation, the major exception to the rule that employers must cover their own employees is in the case of employed children, who are not obligated to accept employment-based coverage if covered under a parent's plan.

Section 303. Definitions

The Committee's intentions with respect to certain special categories of employees and employers affected by this and other sections of the legislation are as follows:

Air craft flight crew and cabin crew.—With respect to aircraft flight crew and cabin crew, hours of service means hours of work, including all time during which an employee is necessarily required to be on duty, either on the employer's premises or at a prescribed work place, or obligated to be available for the performance of duties for the employer.

Temporary help industry.—With respect to the temporary help industry, the Committee concluded that special treatment was required because employment patterns were so dissimilar from other employment situations that failure to establish special rules would create excessive burdens for employers without comparable benefits for employees.

The Committee found that the majority of temporary help service employees either work for very short periods between two jobs—each of which provide health coverage (in many cases, for so short a period that coverage never ceases)—or are covered elsewhere even while working as temporaries (for example, teachers on summer break). Moreover, S. 1265 as originally introduced would have created an excessive administrative burden for temporary help firms because of the rapid turnover and unpredictable tenure of the vast majority of temporary help employees. Fully half of the individuals employed in the industry in a given year work less than 12 days. Accordingly, the Committee has fashioned an amendment which removes any unnecessary burden and at the same time provides access to health coveage for long term, temporary workers.

Under the amendment, temporary help services employees will qualify for health care coverage if they are assigned to perform and complete at least 750 hours of service on behalf of other entities in a period of six consecutive months. Following the initial period of qualification, such coverage must be provided in the month following any month in which such employee performs at least 100 hours of service for the same temporary help firm.

Family farmers.—With respect to family farmers, the Committee concluded that the economic crisis affecting family farms as a group was so severe that imposing additional economic burdens at the present time would be inappropriate. Accordingly, family farms are exempted from the bill until farm prices in the commodity group produced by the farm reach a level sufficient to end the current economic crisis.

It is important to note that there is no permanent exemption for family farms, and the temporary exemption established by the bill is not applied on a farm-by-farm basis. The economic strength of an individual business is not an appropriate basis for determining the economic rights of the employees of that business. Moreover, the definition of a family farm applied by the bill is a strict one, albeit one that has a well-established definition in the current farm laws. A family farm is defined as one that, among other characteristics, has most of the work on the farm performed by the owner or members of the onwer's family. Farms that rely primarily on employee labor are never considered faimly farms, regardless of their size or ownership.

Family farmers, like other small businessmen, face significant difficulties in obtaining affordable health insurance for themselves and their families, as well as their employees. This is particularly true when a member of the family has health problems that may make them a poor insurance risk. The Committee believes that, even if the farm economy has not improved to the extent envisioned in the bill, a majority of family farmers might wish to participate in the regional insurer program in order to gain the benefits of lower price and guaranteed availability of coverage. Since the problem of adverse selection makes participation in the regional insurance program impractical on a voluntary basis, the legislation allows all family farmers in a commodity group to vote on the question of mandatory participation in the program. If a majority of family farmers in a commodity group approve, all farmers in the group would be covered by the legislation, regardless of the level of crop prices.

Child.—The Committee intends the term child to include adopted children from the moment such a child enters the custody of the insured, pursuant to an interim court order of adoption vesting temporary care of the child in the insured, regardless of whether a final order is pending.

Section 311(b). Actuarially equivalent plans

General Considerations.—In including the concept of actuarial equivalency in the bill, the Committee intended to provide flexibility to employers in meeting the requirements of the act, to recognize the considerable variations that currently exist, even among excellent health plans, and to avoid interfering, to the maximum extent feasible, with existing, high quality employment-based health insurance.

As conceived by the Committee, actuarial equivalency allows the employer to vary co-payments, deductibles, the share of the premium paid by the employee and the level of the catastrophic cap as long as the actuarial value of employer contribution to the plan is at least equal to what would have been provided if only a minimum plan had been offered. Thus, an employer that offered a more generous package than the minimum—because it provided additional benefits or because it had a lower deductible or copayment level—could charge the employee or his dependents a higher share of the premium. Conversely, an employer that had higher copayments or deductibles could maintain compliance with the actuarial equivalency requirement by paying a higher share of the premium than would otherwise be required. Other variations would also be allowed; for example, an employer could have a higher deductible and a lower stop-loss. Of course, procedures or arrangements (such as increased copayments for failure to utilize limited panels of providers or failure to secure preadmission certification) allowed under Section 312(e) would not be taken into account in determining whether a plan is actuarially equivalent.

In the Committee's view, the actuarial equivalency concept gives employers ample flexibility to tailor plans to meet their own special needs and circumstances. As expressed in the Committee bill, however, actuarial equivalency is not unlimited. It does not allow an employer to fail to cover any of the basic services—hospital care, physician care, diagnostic tests, pregnancy and well baby care, limited mental health benefits—enumerated in Section 312(a). It does not allow limitations to be placed on coverage of those services other than requiring that services be medically necessary, permitting non-coverage of experimental procedures, and permitting non-coverage of routine physical exams or preventive care. It does not allow an employer to require payment of co-payments or deductibles for prenatal and well-baby care. And it does not allow an employer to provide a plan that does not have a catastrophic stop-loss, although the employer may adjust the level of the stop-loss according the principle of actuarial equivalency.

Mental health benefits.—In providing mental health benefits, the bill allows employers to craft a mental health benefit that is most suited to the needs of their employees, if that benefit is actuarially equivalent to the benefit specified in Section 312(a)(5). For example, the employer could provide for fewer outpatient visits but with al- lower co-payment, or hospital days could be more limited if outpatient visits were expanded. However, any mental health benefit must provide for some hospital inpatient services and some outpatient psychotherapy and counseling services. In addition, the Committee recognizes that there are other appropriate modalities for treatment of mental disorders than hospitals and outpatient visits for psychotherapy or counseling. The Committee intends that employers be allowed and encouraged to establish coverage for alternative, actuarially equivalent treatment modalities that may be most appropriate for particular patients and particular mental disorders. The Committee recognizes the positive contributions to the health of employees and dependents that can result from employee assistance programs (EAPs). It is the intent of S. 1265 that EAPs meeting standards established by the Secretary in regulations be considered part of the plan for purposes of actuarial equivalency and meeting other standards of the act.

Establishment of actuarial equivalency.—The Committee is aware that some employers, while applauding the concept of actuarial equivalence, are concerned that establishment of actuarial equivalency might prove burdensome for an individual business. The Committee intends that the Secretary shall establish methods for establishing actuarial equivalency that shall be simple and practical. It also intends that employers not be penalized if the Secretary finds a plan not to be actuarially equivalent, if the employer has made a good faith effort to establish an actuarially equivalent plan.

To facilitate employer efforts to establish actuarially equivalent plans, the legislation specifies that the Secretary shall publish, at least three months prior to the effective date of the act, a table of actuarial equivalency that will cover as many health insurance plan variations as feasible. The table will establish relative weights for health insurance options, expressed as a percentage increase or decrease from the minimum plan. The Committee intends that any employer plan found to be actuarially equivalent by the mechanical application of this table shall be considered actuarially equivalent. In cases where the employer wishes to establish a plan that includes variations not covered by the table or in cases where the employer wishes to give a different weight to variations than provided in the table, the employer may do so if he has made a good faith effort to establish actuarial equivalency and his plan has been certified as actuarially equivalent by an actuary meeting credentials established by the American Academy of Actuaries or by the Secretary. While the Secretary could find such a plan out of compliance at some subsequent date, the Committee intends that the Secretary shall not do so except in cases where the violation of actuarial equivalency is clear and persuasive. Moreover, no penalties could be applied to the employer for any period of non-compliance prior to an affirmative finding on non-compliance, as long as the employer made a good faith effort to comply and followed the procedure described above.

The Committee recognizes that, in the case of an employer with many plans, it might be unduly burdensome to go through a full certification process for each plan. The Committee intends that the Secretary shall establish in regulation streamlined procedures for the certification of such multiple plans. For example, the Committee believes that the Secretary might reasonably specify that if an employer has certified one plan to be actuarially equivalent of better than the minimum plan, all additional plans offered by the employer would be considered actuarially equivalent to the certified plan if the employer's cash contribution to the alternative plan were equal to or higher than the contribution made to the certified plans for equivalent categories of enrollees.

The Committee assumes that in the case of plans provided by an insurance company—and in particular in the case of plans purchased through the system of regional insurers established by the bill—the responsibility for assuring actuarial equivalency of the plan shall rest with the insurer.

To assist the Secretary in addressing all the issues surrounding actuarial equivalency, the legislation establishes an Advisory Board. The Committee expects the Secretary to give due weight to the recommendations of this board in formulating the table of actuarial equivalency and in all other matters relating to the administration of the actuarial equivalency requirements of the law.

Section 312(a)(2). Inpatient and outpatient physician services

As for other services specified by the bill, the Committee intends that all medically necessary physician services are required to be covered, unless those services are experimental or are routine physical examinations or preventive care. In particular, the Committee wishes to emphasize that medically necessary prenatal, delivery and postpartum care, including services for complications of pregnancy, labor, and delivery and postpartum recovery care are included as services required to be covered under both this subsection and under 312(a)(1) and 312(a)(3).

Section 312(a)(4). Prenatal and well-baby care

The legislation requires provision of prenatal and well-baby care for children under one year of age without co-payments and deductibles because the Committee believes that this care is cost-effective and essential to lowering rates of infant mortality and preventing long-term disabilities. The Committee is aware of concerns, however, that the benefit could become an open-ended one, with other services that are not as essential reclassified into the category of prenatal and well-baby care. The Committee intends that the services covered by the special pre-natal and well-baby benefit be limited to specific services specified by the Secretary in regulations, with the amount and frequency of covered services also specified. In writing these regulations, the Secretary should give careful consideration to the standards for prenatal and wellbaby care established by such scientific and professional societies as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. The Committee intends that these standards, once established in regulation, will be changed only if there are substantial alterations of the generally accepted definitions of appropriate medical practice in these areas.

In establishing these limits on the scope of required prenatal and wellbaby care, the Committee does not intend to limit other medically necessary services to expectant mothers and infants. Such services would be required to be covered under the general requirements for coverage of medically necessary physician services, hospital services, and diagnostic tests. Such additional services, however, could be subject to the normal co-payments and deductibles required by the employer's plan.

Section 312(a)(5). Mental health services

In defining mental health professionals whose services would be required to be covered for outpatient psychotherapy and counseling, the bill refers to "duly licensed or certified" professionals and facilities. This phrase will generally refer to state licensure and certification, if consistent with the standards established by the Secretary in accord with 312(h). In some states, however, there is no provision for licensure or certification of certain mental health professionals and facilities. In such cases, recognition by the relevant professional body or by the Secretary will be sufficient, if consistent with the regulations of the Secretary.

There are a number of mental health disciplines that are appropriate for reimbursement for provision or outpatient psychotherapy and counseling. The Committee adopted the qualifications of licensed or certified clinical social workers as the basic standard for required coverage under the bill. Licensed or certified clinical social workers are social workers who: (1) possess a master's or doctor's degree in social work from a school of social work accredited by the Council on Social Work Education; (2) after obtaining such degree have performed at least two years of supervised clinical social work; and (3) are licensed or certified as a clinical social worker in the state in which the individual's services are performed, or, in the case of an individual in states which do not provide for licensure or certification, is certified by a national professional organization offering certification of clinical social workers.

In determining whether mental health professionals, other than physicians, clinical psychologists and clinical social workers are "equivalent mental health professionals" under the terms of the bill, the Committee intends that the Secretary shall establish criteria to determine this equivalency including the length of formal training and education required for certification for the profession under consideration, the amount of supervised clinical work the members of the profession are required to perform prior to certification or licensure, the quality of the training programs prevailing for the profession, the association of formal training programs with high quality institutions of higher education or academic medical facilities, and any scientific evidence available of the effectiveness of psychotherapy and counseling provided by members of the profession compared to clinical social workers.

Thus, for example, an individual who possesses a master's degree, has completed two years of supervised clinical experience, is licensed or certified by a state regulatory agency or is eligible for recognition by a relevant professional body, and provides outpatient therapy or counseling to individuals, couples, and families, shall be deemed an "equivalent mental health professional."

With regard to clinics or centers providing duly licensed or certified mental health services, the Committee intends that the Secretary shall establish standards for such centers and that state licensure or certification or certification by appropriate accrediting bodies, consistent with standards established by the Secretary, shall qualify a center under this section. The Committee intends that clinics or centers accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Council on Accreditation of Services for Families and Children would generally qualify under this section.

The Committee is aware that there is a range of mental disorders, and that standards qualifying a center or clinic for treatment of one category of mental disease may not be appropriate or applicable for other mental diseases. The Committee intends that the Secretary shall establish standards of qualification that may be different for centers specializing in the treatment of particular categories of mental disorders, consistent with the best recognized professional practice and certification and licensure standards.

This subsection establishes a basis for determining which mental health professionals and facilities are required to be reimbursed by employment-based health insurance plans for services required under this subsection. Neither this legislation nor regulations issued by the Secretary pursuant to this subsection shall be considered to change or override state legislation establishing scope of practice for various professions or facilities or to be construed to require modification of hospital practices with regard to scope of practice, admitting privileges, or billing arrangements.

The special limitations in this subsection for outpatient psychotherapy and counseling for treatment of a mental disorder are not intended to place limits on all outpatient mental health services. The Committee does not intend to place special limits on other services for the treatment of a mental health disorder, which would be covered under Section 312(a)(2) and Section 312(a)(3). The Committee understands that such services, exclusive of psychotherapy or counseling except when psychotherapy or counseling was conducted as an incidental part of a medical management visit, are commonly referred to as the medical management of a mental disorder. The Committee intends such medical management to refer to the office medical and home medical services for either a new or established patient, and to include brief, limited, intermediate, extended, comprehensive, and consultation services, except in cases in which such services consist of psychotherapy or counseling unless such psychotherapy or counseling is provided as an incidental part of a medical management visit. In addition, the Committee does not intend to allow special limitations on mental health services provided as part of a covered period of inpatient care.

With regard to inpatient care, the Committee recognizes that appropriate treatment for many mental disorders includes a continuum of inpatient services. With regard to services provided under 312(5)(A), the Committee intends the term "inpatient hospital services" to include medically necessary actuarially equivalent periods of inpatient treatment in any residential facility accredited by the Joint Commission on the Accreditation of Health Care Organizations or meeting equivalent standards established by the Secretary in regulations.

Section 312(e). Limitations

In establishing the requirements for covered services and for payments for services provided for certain categories of providers under Section 312(a), the Committee does not intend to hinder the ability of employers and insurers to establish cost-effective managed systems of care, such as HMO's and PPO's. Accordingly, the provisions of Section 312(a) should not be construed as prohibiting a plan from establishing a limited panel of providers eligible to be reimbursed for care or for specific types of care, and the limitations set forth in this subsection are applicable to all of the care provided under section 312(a), including inpatient and outpatient mental health care.

This subsection makes it clear that employers and employees may select particular health care providers, or types, classes, or categories of health care providers to participate in such panels. However, in order to apply these types of restrictions, there must be a bonafide panel or managed care system based on selection of individual providers. In addition, nothing in section 312(a) should be construed as requiring plans to pay different providers or different types, classes or categories of providers the same amount for similar services. Finally, if a plan covered a service required under 312(a) prior to January 1, 1988, but did not utilize a particular category of provider specified in the act prior to that date, the plan would not be required to reimburse such providers during a five year period beginning on the effective date of this act.

The Committee also intends to allow employer to establish reasonable cost containment procedures (such as increasing copayments for failure to secure a pre-admission certification) and other requirements or procedures which enable an employer to ensure that health care paid for by the plan is necessary.

While the Committee intends to give employers and insurers maximum freedom to construct cost-effective mechanisms for delivering care, the establishment of limited panels of providers should not be a cloak for denial of access. Therefore, the Committee intends that the Secretary shall establish reasonable standards of access to care that plans that require receipt of care from a limited group of providers would need to meet. In cases where access to care was grossly inadequate, a plan would be considered to be out of compliance.

Section 312(f). Basis of Payment May Differ From Actual Charges

This provision emphasizes the Committee's desire to give employers and insurers maximum flexibility to control costs. Nothing in this legislation requires the payment of full charges by a plan. At the same time, the Committee is aware that allowing total freedom to set charges could vitiate the purpose of the act by permitting a plan to pay an amount for a covered service that would be so low as to deny plan participants access to services or that would allow access to services only on the payment of costs in addition to what the plan would reimburse, thus vitiating the insurance protection promised. Accordingly, the act allows a plan to establish any basis for payment that it believes would contribute to the economical and effective delivery of services to plan beneficiaries, as long as a number of providers in an area sufficient to provide reasonable access to care willl accept plan reimbursement as payment in full except for co-payments and deductibles. The bill requires the Secretary to establish in regulation standards that will achieve this objective without unduly limiting the ability of a plan to assure that services are delivered economically.

Section 312(g). New Small Businesses

The Committee is aware that new, small businesses are particularly fragile economically during their formative years. Accordingly, this section provides that a business that employs ten or fewer workers and is less than two years old may meet the requirements of this act by providing catastrophic coverage only.

Section 312(h). Mental health care

Subsection 312(h)(1) provides that physicians and duly licensed or certified clinical psychologists, at a minimum, may provide inpatient mental health care. However, this subsection makes it clear that this provision is not intended to alter any existing hospital practices concerning the scope of practice, admitting privileges, or billing arrangements. Also, the limitations set forth in section 312(e) apply to inpatient mental health care, as well as the other benefits which health benefit plans are required to provide under section 312(a).

In specifying a group of non-physician providers required to be reimbursed for outpatient mental health services under section 312(a)(5)(B), the Committee recognizes that these providers provide high quality, appropriate services and that coverage of such providers is essential for adequate access to care in many areas of the country and promotes cost-effective delivery of needed care.

At the same time, the Committee recognizes that many current health plans provide coverage for outpatient mental health services and adequate access to service for plan participants but restrict the types of providers eligible to be reimbursed for services to a more limited group than is specified in section 312(a). The Committee believes that, over time, these plans will voluntarily choose to cover the full range of providers specified in this Act. However, in keeping with the Committee's desire to interfere as little as possible with existing health benefit plans providing high quality coverage to plan participants, Subsection 312(h)(2) makes it clear that no health benefit plan shall be required to utilize duly licensed or certified clinical social workers, duly licensed or certified equivalent mental health professionals or clinics or centers providing duly licensed or certified mental health services to provide outpatient mental health care benefits that were provided by the plan before January 1, 1988, unless the health benefit plan was utilizing such health care providers on January 1, 1988. New health benefit plans, including coverage provided by regional insurers, and plans not currently covering outpatient psychotherapy and counseling actuarially equivalent or better to that required by this act would be required to provide coverage and reimbursement for the set of providers specified in 312(a)(5)(B). For clinical psychologists, clinical social workers and other duly certified equivalent mental health care professionals, the Committee intends that plans may not routinely require supervision or referral by another type of mental health professional as a condition for reimbursement. However, the Committee does not intend to prohibit pre-approval, utilization review, quality assurance or other procedures commonly used to assure the necessity and appropriateness of medical care, and, of course, the limitations set forth in 312(e) are applicable to all providers, including providers of mental health services.

Section 314(b)(1)(D). Premium categories for two-worker families

A general principle embodied in this act is that each employer should have primary responsibility for the insurance coverage of his or her own employees. Enactment of this bill will relieve some employers that currently bear primary responsibility for insurance of both members of a two worker family of significant costs by shifting primary responsibility for one member of the family from the currently insuring employer to the employer of that family member. While this provision represents a significant saving for the employer, it could represent a significant cost for the worker in the case of contributory plans, since, if no other premium changes occur, the savings to the workers would be spread across all employees buying family plan coverage, while the costs would fall only on dual worker families that would not have to contribute to an additional plan.

Accordingly, this subsection requires that employers create a new category of coverage for two worker families for purposes of calculating the employee's share of the premium—family plan coverage in which a spouse receives primary health insurance coverage under another plan. This change would not affect the cost savings accruing to the primary employer, but it would ensure that the workers' share of the savings in plan costs would go to families with two employees, rather than being spread across all workers. Under this structure, premium reductions to the spouse employed by the primary employer should roughly cancel out premium increased to the spouse employed by the secondary employer.

The Committee recognizes that precise calculations of the premium savings accruing to this category of workers would be difficult, and it is not the Committee's intention to create an administratively burdensome requirement. Accordingly, the Committee directs the Secretary to suggest a formula or formulas for calculation of premiums in these categories and intends that any reasonable formula used by an employer based on estimated or actual plan experience shall meet the requirements of this subsection.

Section 314(b)(4). Withholding permitted

The legislation requires an employer to offer and an employee to accept plan coverage. Some employers have expressed concern that they may be held liable for plan noncompliance if an employee refuses coverage and does not contribute to the plan. This provision seeks to alleviate this concern by explicitly authorizing withholding of any required employee contribution to the plan. Employers should have no more difficulty in enforcing employee compliance than they do in withholding required employee contributions to Social Security and Medicare.

Section 314(c)(2). Wage-related deductible

In general, the Committee believes that wage-related deductibles are more equitable and serve the appropriate function of a deductible in deterring unnecessary use of health care services better than a flat dollar deductible. Flat deductibles are likely to deter both necessary and unnecessary use of services by lower income employees, while having little impact on more affluent workers. Since only a small minority of employers currently use wage-related deductibles, the Committee felt it would be excessively intrusive to require such an approach. This subsection makes clear, however, that a reasonable wage-related deductible is an acceptable alternative to the flat-rate deductible levels specified in the minimum plan. A similar approach was taken by the Committee with regard to wage-related catastrophic caps on stop-loss out-of-pocket expenses for covered services.

Section 314(d)(2) and 314(d)(3). Exceptions to copayment and coinsurance limits

In establishing limits on coinsurance and out-of-pocket payments the Committee intends to insure financial protection and access to appropriate care to working men and women and their families. The Committee does not intend to interfere with legitimate efforts of employers and insurers to encourage cost-effective utilization of care by employees or to restrict efforts to assure that care is in fact necessary. Accordingly, these subsections make clear that the minimum coinsurance and copayment standards of this act do not apply in cases where the plan requires beneficiaries to pay higher out-of-pocket amounts if they use providers not designated by the plan or if beneficiaries obtain services without complying with reasonable procedures established by the plan to ensure efficient and appropriate utilization of covered services.

Subtitle C—Certification of Regional Insurers

The regional insurer program established by this act is designed to improve the ability of small businesses to buy health insurance by reducing cost and guaranteeing availability.

In the current small business insurance market, insurers protect themselves against adverse selection by aggressive medical underwriting. Medical underwriting is the practice of examining the health status and characteristics of employees and basing decision to cover or not to cover and what prices to charge on this examination. This practice has the effect of denying the availability of insurance to some small businesses and to some employees of small business even when the business wishes to offer coverage. In addition, insurance sold in the small business market typically includes pre-existing condition exclusions which deny insured individuals coverage of the very conditions for which they need insurance the most. Finally, medical underwiting results in much higher than average health insurance costs for small businesses with older workers, and for small businesses located in areas with higher than average health care costs.

Partly because of the parctice of medical underwriting, as well as other characteristics of the small business market, there is a considerable amount of "churning" in health insurance coverage. In other words, small businesses change insurance carriers much more frequently than large businesses and also drop an add coverage more frequently, Churning adds to the administrative and sales costs involved in serving small business and is reflected in higher prices for health insurance. The one on one sales effort that is necessary in the current small business market also adds to cost. Finally, competition is not as effective in reducing costs in the small business market as might otherwise be the case because small businesses do not have the specialized staff necessary to examine health insurance alternatives carefully and because insurance is not sold in a standardized form that would permit easy comparison of prices for similar coverages offered by different companies.

The mandatory coverage requirements of this act will reduce costs for small business somewhat by reducing churning. Since small businesses, like other businesses, will be required to purchase health insurance for their workers, small businesses will no longer drop in and out of coverage. Moreover, mandatory coverage reduces the necessity of medical underwriting to avoid adverse selection, since individuals and businesses will no longer be in a position to make a decision whether or not to purchase health insurance coverage based on expectation of future health costs.

In setting up a process for certification of the regional insurers allowed to compete in the small business market, the Committee wished to maximize effective competition and reduce administrative and sales costs to the maximum extent feasible. Accordingly, any insurer could be certified by the Secretary that meets the requirement of the statute. In certifying insurers to be regional insurers, the Secretary must assure himself or herself that the organization certified meets such standards of financial stability as the Secretary may establish, meets the requirements of section 323 (described below), agrees to enroll any employment-based group eligible to enroll with a regional insurer that chooses to enroll with that organization, agrees to offer only plans and plan options approved by the Secretary, agrees that if it offers a managed care insurance program in the region in its regular line of business that it will also make that program available in its capacity as a regional insurer, and agrees to allow its offerings to be listed in material distributed by the Secretary in such form as the Secretary may prescribe and agrees to enroll businesses wishing to enroll by mail by accepting a completed form to be contained in such materials.

In fulfilling the last requirement, in conjunction with the requirements of Section 323, the Committee intends that the Secretary develop a set of standard plans and plan options in consultation with the insurance industry and others and with the insurers wishing to be certified as regional insurers. These plans would include both a minimum plan and a comprehensive plan, as required by the Act, and would also include options in between the minimum and comprehensive plan representative of major variations present in the market, such as alternative copayment, deductible, and catastrophic cap levels, and coverage of optional benefits such as prescription drugs, eyeglasses, dental care, and more extensive mental health care than required by the act.

All plans and plan options should be standardized to the maximum extent feasible, so that a small businessperson wishing to choose a plan, could, by scrutiny of the material issued by the Secretary, make a quick and simple comparison of the cost of each plan option as offered by different regional insurers. The Committee intends that the Secretary, in working with prospective regional insurers to develop the plan offerings and in developing material describing them, shall strive to assure simplicity and clarity of choice, while maintaining a reasonable range of available coverage options.

In determining whether or not an insurer meeting the requirements of the act is allowed to become a regional insurer, the Secretary is required to consider, with respect to each applicant, the price of health benefit plans proposed to be offered by the applicant, the quality and types of services to be provided under the plans, the experience of the applicant in providing and managing health benefit plans, and the financial stability of the applicant. The Committee intends that, in order to promote effective competition and to lower the cost of the plans, the Secretary shall certify as many regional insurers as meet the requirements of the Act as is consistent with this objective. If, in the judgment of the Secretary, the number of plans wishing to be certified as regional insurers is too high to further this goal, the Secretary shall use these criteria to limit the number of certified regional insurers.

To facilitate small business enrollment with regional insurers and to assist small businesses in the choice of the most economical and appropriate plans to meet their particular needs, the Secretary is required to provide technical assistance and informational materials, including enrollment forms, to small businesses. The Secretary is required, to the maximum extent feasible, to enter into contracts with small business service bureaus, chambers of commerce, and similar organizations to provide this assistance to small business.

Based on estimates of the Actuarial Research Corporation and consultation with a number of experts in the insurance field, the Committee has concluded that the regional insurer structure will lower the cost of insurance to small businesses by ten percent, as the result of decreased sales and administrative costs and more effective competition. The availability of systems of managed care through the regional insurer structure will lower costs an additional fifteen per cent or more, for a total potential saving to small business of 25 per cent compared to currently available health insurance offerings.

Section 401. Effective date

Based on testimony from F. Gerard Adams at its November 4, 1987, hearing that a phase in period would reduce the economic impact of this act on small business, the Committee has included a five year phase in period for application of the law to businesses with five or fewer employees.

Section 402. Policy respecting additional benefits

The Committee is aware of concerns of many businesses that are supportive of the general thrust of this legislation and are comfortable with the benefit package included in the bill that future Congresses may expand the required benefit package unduly in response to public and health care provider pressure. This concern is particularly strong since private employer mandates do not entail significant direct Federal budget costs, and, thus, the normal discipline of the Federal budget process does not apply.

In response to those concerns, the Committee has included several safeguards against a future Congress's indiscriminately adding additional benefits. First, this section requires that no benefits may be added unless they are also required benefits under the Medicaid program for cash assistance recipients. Thus, the addition of further mandated benefits would require a judgment by the Congress that these additional benefits were valuable enough to justify additional expenditures of both State and Federal funds. State governments, who must share in the cost of the Medicaid program, would also have an interest in opposing additional mandated benefits unless their benefits were found to outweigh their costs. Moreover, since Senate jurisdiction over the Medicaid program is lodged in a different committee than is jurisdiction over the program established by this act, at least two Senate committees would have to be involved in the judgment that expanded benefits would be desirable.

In addition, this section specifies that no benefit could be added as a mandated benefit unless the benefits and costs of such additional benefit had been carefully analyzed by independent experts.

X. ADDITIONAL VIEWS

At the outset we want to reaffirm our commitment to the underlying objective of S. 1265 to make health care accessible to all working men and women and their families. As noted in this report, there are currently 37 million people in this country who are uninsured. Since 1980, the number of uninsured has grown at a rate of one million per year, and is expected to continue to increase in coming years. Of these uninsured, some 24 million are employed full time or are the dependents of full time workers. Most earn less than 200 percent of the poverty level and are among a growing group of so-called "working poor." They generally do not earn enough to pay for health care, but at the same time, do not qualify for government assistance. When confronted with illness, they must seek charity care or forego care altogether. Neither alternative is acceptable—the first robs their dignity, and the latter their health.

We support not only the goal of this legislation but also the solution it embodies: the concept of addressing, in part, the problem of the uninsured through a mandate requiring employers and employees to jointly participate in paying for the cost of health care coverage. This approach makes sense and is consistent with a number of other requirements for employers and employees that have added immeasurably to the welfare of the American people. For example, unemployment insurance protects workers against the economic dislocation associated with periodic unemployment. Workers' compensation provides a source of recovery for individuals who suffer injuries on the job. Social Security and Medicare assure retirement income and needed health insurance protection in old age. These are all examples of programs financed jointly by mandatory contributions from employers and employees aimed at resolving problems of broad social and economic significance.

Although we stand committed to the concepts which underlie the Act, we have concerns about the cumulative impact which this bill, and other currently under consideration by the Committee on Labor and Human Resources, may have on small businesses if not appropriately phased in and calibrated. In the near future, the Committee will consider bills aimed at increasing the minimum wage and entitling workers to unpaid family and medical leave. Although we will be called upon to consider each of these bills separately, our concern is for their cumulative effect. In our view, it is impossible to pass any one of these measures without considering what has been or may be done with respect to others.

We have several additional concerns and we will continue to work with the Chairman to resolve them. Among them is the requirement that regional insurers market beyond state lines, even where, as in the case of Blue Cross/Blue Shield plans, insurance programs have been regulated and conducted exclusively within individual states. In addition, because premiums are to be calculated on a community-rated basis, we are concerned about possible inequities within regions as the result of the subsidization by states with lower health care costs of those states with significantly higher costs.

We want to make it clear that in stating our concerns, we in no way intend to offer ammunition to those who oppose these measures. We are committed to providing minimum health insurance for all working Americans, as well as a minumum wage and medical and family leave, and we intend to work for legislation to achieve these ends, while preserving the financial integrity of the small business community.

BROCK ADAMS.
BARBARA A. MIKULSKI.
CLAIBORNE PELL.

ADDITIONAL VIEWS ON S. 1265

At the outset, we want to reaffirm our strong commitment to the underlying objective of the Minimum Health Benefits for all Workers Act--to assure health insurance coverage for the millions of working Americans and their families who are currently without any coverage.

Millions of our fellow citizens face a growing crisis in access to essential health care. Thirty seven million Americans currently have no health insurance coverage—and the number has been rising by a million a year since 1980. Approximately two thirds of the uninsured are members of families in which at least one member of the household works full time; these workers and their dependents deserve access to essential care.

However, we do have concerns about some of the provisions in S. 1265. Among them are establishment of regional insurers and the requirement that regional insurers market beyond state lines, even though insurance programs traditionally have been regulated and conducted exclusively within individual states. We are also concerned about whether the regional insurance structure, as currently conceived, is the most effective, competitive approach to providing affordable insurance to small businesses and will generate minimum administrative costs. In addition, because premiums are to be calculated on a community-rated basis, we are concerned about possible inequities within regions as the result of the subsidization by states with lower health care costs of those states with significantly higher costs. We would also like to see included in the act further cost-containment measures, such as provision of reimbursement for low-cost providers.

In stating these concerns, we in no way wish the convey less than enthusiastic support for the overall objective of the legislation—providing health insurance for the millions of working Americans who currently are uninsured. We will continue to work with the chairman to achieve the goals of the Minimum Health Benefits for All Workers Act.

Tom Harkin.
Christopher J. Dodd.

XI. MINORITY VIEWS ON S. 1265

We oppose S. 1265 and the accompanying Committee views, and we support Senator Quayle's additional dissenting views. In the existing tight budget situation, a majority of my colleagues on the Senate Committee on Labor and Human Resources have chosen to achieve their social objectives by requiring private employers to provide a vast array of benefits of all employees, regardless of cost, regardless of the desire of the employees, regardless of the impact upon jobs, and regardless of their impact upon our overall competitiveness in existing domestic and world markets. S. 1265, the Minimum Health Benefits for All Workers Act of 1988, requires that all employers, as a condition of doing business, provide a mandated health insurance package to all their employers who work over 17½ hours per week.

This bill will directly affect American workers. It will reduce their paychecks; it will reduce their flexibility in selecting benefits; and it will force many workers out of a job as employers look for ways to reduce their operating expenses. In sum, S. 1265 is a hidden regressive tax imposed upon virtually every American worker. And, more importantly, this legislation fails to respond effectively and realistically to a real problem in our nation—uninsured workers.

THE PROBLEM OF ACCESS TO HEALTH CARE IS REAL

There are approximately 37 million Americans who lack health insurance. All of us share a concern about these citizens and an interest in finding methods to ensure their access to health care. At the same time, however, we must realize that solving this problem is extremely difficult primarily because, as The Urban Institute has reported, the diversity of problems experienced by the uninsured defy simple solutions. Despite these facts, the majority would have us impose a simple solution—a single answer which is costly and will do more harm than good in providing access to health insurance for American workers—on virtually every single employee and employer throughout our nation.

The best profile of the uninsured has been done by the Employee Benefits Research Institute, and it shows that the uninsured are a very diverse group, who come from all income groups and includes employed, self-employed and unemployed individuals. About 32% of the uninsured are in households with incomes below the federal poverty threshold (10,989 for a family of four in 1985). Another 30% have incomes between one and two times the poverty threshold.

While no one solution will provide a comprehensive answer for the uninsured, S. 1265 is particularly misguided because it misses the vast majority of those most in need of health coverage. Almost three quarters of the uninsured workers make less than $10,000 a year and may be in the worst position economically to absorbe the cost of the imposed mandate. The bill provides nothing for the uninsured living in households in which the head is unemployed (5 million) or self-employed (3 million) and it will do little for the 12 million people living in households where the head was employed only part-time or intermittently.

According to the Small Business Administration, the working uninsured can be categorized as follows: 46% of the firms with fewer than 10 workers offered health benefits, compared with 78% with 10 to 24 workers, 92% of firms with 25 to 99 workers, 98% of firms with 100 to 499, and 100% of firms with 500 or more works. Eighty-four percent of all workers who worked for employers without health plans worked in firms with less than 25 employees. These firms are the ones that will be most directly affected by the bill.

Currently, employer-sponsored plans provide valuable protection for over 130 million individuals. In 1985, employers paid over $105 billion for the health care of their employees, retirees, and their families. We have a very diverse and sophisticated system of insurance health which is predominantly paid for through employer-based health insurance programs. Granted, there are some gaps in coverage, real gaps on which Congress and others should focus their attention, but this marketplace may be the source of a more economical, realistic, and adaptable solution than the one mandated in S. 1265.

IMPACT ON SMALL BUSINESS

Small employers are least likely to provide health care benefits because they are characterized by low and uncertain profits, high employee turnover, low-wage earners, and part-time workers. The Small Business Administration studied why small employers do not offer health insurance and provided the following specific conclusions:

(1) They face higher per worker premiums since the risk for insurers is spread over fewer persons;

(2) They do not gain the same tax benefit as larger firms offering health insurance;

(3) They experience higher costs in choosing and administering a health plan;

(4) They have relatively higher worker turnover rates and a greater use of part-time and seasonal employees which increase administrative fees; and,

(5) They tend to have narrower profit margins from which to pay relatively higher premiums.

These factors, coupled with the explosive growth in health care costs, have put the price of health coare coverage beyond the means of many small employers as well as some medium and large companies. Mandating coverage, as required through a phase-in under S. 1265, puts small businesses at odds with these econmomic realities, and could result in increased business failures, increased unemployment, and general economic disruption.

According to David Birch at MIT, during 1986 over 70 percent of all new jobs were created in firms with 100 employees or less, and

70 percent of that number are in firms with fewer than 20 employees. Small business is the engine of our economic growth. It is our source of new jobs and new opportunities. By enacting S. 1265, we run the dangerous risk of stifling this prolific source at a time when it is desperately needed.

EXPECTED JOB LOSS

There is a general consensus that there will be some economically damaging disemployment effects if S. 1265 is enacted and that the greatest harm would fall most heavily on two groups already at a disadvantage in the labor market: minority youth, because they are young and inexperienced and earning relatively low wages; and small marginal businesses with uncertain profits, high turnover, and a high proportion of minimum wage workers.

The majority points to estimates based on the Data Resources Institute Model which indicate that between 100,000 to 120,000 jobs will be eliminated by S. 1265. They also point to Dr. Karen Davis, estimates that only 60,000 jobs will be lost. The Congressional Budget Office indicates that substantial cost increases would result in the reduction of hourly wages of the lowest-wage workers, C.B.O. estimates that the hourly costs of the bill to be about $0.65 per hour. Many economists have concluded from the vast number of studies that have been made of the effects of the minimum wage, that a 20 percent increase in the wage reduces employment by about 1 to 3 percent. Consequently, several experts, such as Dr. Thomas Moore, who is a member of the President's Council on Economic Advisors, have used the minimum wage model to estimate that the disemployment impact of S. 1265 ranges between 100,000 to 400,000 lost jobs lost in any one year. The Institute for Research on the Economics of Taxation has estimated total job at 1 million if S. 1265 is enacted. In sum, the experts have predicted that S. 1265 will eliminate the jobs of between 60,000 and 1 million Americans working today, an incredible price to pay for any legislative proposal, let alone one which purportedly promises to help the working men and women of this nation.

COSTS ASSOCIATED WITH S. 1265

Mandating health insurance will increase the cost of doing business. While there are no exact numbers regarding who will be covered and at what precise cost in terms of premiums, a range of estimates have been provided to the Committee. They are as follows:

ESTIMATED PREMIUM COSTS OF S. 1265 [1]

	Premium costs	
	Single	Family
Health Insurance Association of America	$870	$2,364
Acturaial Research Corporation	708	1,798
Nathan Associates	1,176	2,986
Institute for the Economics of Taxation	1,200	2,892

[1] Estimates received prior to addition of mental health benefits.

Using the premium costs and multiplying it by the estimate number of uninsured workers likely to be covered, the following represents the cost of S. 1265 for coverage of new employees only:

ESTIMATED COST OF S. 1265 FOR WORKING UNINSURED

	Premium cost [1]		Total cost (billions)
	Single	Family	
HIAA	$870	$2,364	$32.7
Actuarial Research Corporation	708	1,798	25.1
Nathan & Associates	1,176	2,986	33–39
IRET	1,200	2,892	36.9

[1] Does not include added mental health benefit.

Furthermore, a majority of the currently offered private health insurance plans don't meet the bill's minimum requirements. A survey conducted by Towers, Perrin, Forster, and Crosby showed that not one large employer provided the benefits required. Of 4,481 companies surveyed by the United States Chamber of Commerce, none met the requirements of S. 1265. The Nathan and Associate Studies concluded that, given the enormous variation among policies, one can say confidently that many employers who now provide insurance would have to make some change in their policies. Probably the most widespread change would be to provide prenatal and well-baby care and to do so without deductibles. Another change would be to extend coverage to part-time workers. According to the majority, both of these requirements are mandatory. Consequently, the actual costs associated with increasing existing plans to meet the minimum level required range from $2 billion (by CBO for federal, state and local employees) to $16.3 billion by IRET.

Nevertheless, these premium estimations are low given the fact that health care inflation is rising at three times the rate of general inflation. According to an article by Glen Kramon in the New York Times, the costs of premiums have risen from 10 to 70 percent, with the norm between 12 and 25 percent, based on interviews with many instances, business, and academic experts.

LOSS OF FREEDOM OF CHOICE IN SELECTION OF HEALTH BENEFITS

Freedom to choose not only one's occupation but also one's employer has been a fundamental principle of the American system Many workers are attracted to a particular firm because it offers a preferred set of benefits. Mandated benefits constrain such choices. Federal law specifying the precise requirements of a health insurance package, or any particular level or type of health care benefits, does not take into account the employer's economic position or the particular needs of its workers.

S. 1265 forces a single set of health benefits upon all employees, requiring them to receive such coverage and mandated benefits regardless of their own desires. For example, an employer whose employees are all over child-bearing age is required to provide well baby care benefits to their employees, regardless of their employee's needs or desires. Furthermore, employees as a condition of employment, must accept them despite their preference for other types of benefits.

INCREASED REGULATION

We disagree that there will be minimum regulatory burden associated with S. 1265. Mandated coverage carries with it a serious risk of onerous insurance regulation. It contemplates an extensive role for the Department of Health and Human Services in overseeing this program and in promulgating rules and regulations ensuring that employers are in compliance. It also includes significant limitation on medical underwriting, preexisting condition, and rating factors.

Specifically, regulation under S. 1265 would be primarily concerned with assuring that employers provide the mandated coverage. To allow for flexibility in plan design, the bill permits benefit and cost sharing specifics to fall short of prescribed levels as long as a plan is equivalent in overall "actuarial benefits." I think it likely that this approach would prove unworkable in the face of real-world plan diversity and discordant motivations of some employers. The most likely outcome would be that regulators would resort to testing plan adequacy according to a simple dollar spending criterion. Plans would be in compliance if an employer's annual per-employee outlay met or exceeded a set minimum. Although this mode of regulation is relatively straight-forward, it will stifle incentives that now encourage employers to seek—and carriers to offer—cost-reducing innovations in health plan design and administration. The result would be to weaken cost containment initiatives in the private sector.

As federal agencies assume regulatory and enforcement responsibilities, Congress itself would undertake an active oversight role in policing such efforts. Congress likely will apply its legislative powers to expand control over health care financing. The outcome of this political process will be an intrusive federal presence in employer and health management decisions over delivery, technology, price and quality of medical care. It should be no surprise that S. 1265 is a backdoor attempt to institute a nationalized health insurance program.

HEALTH CARE COST INFLATION

Mr. Anthony Gadja, Employee Benefit and Compensation Analyst of William M. Mercer-Meidinger-Hansen Inc., predicted the following regarding health care cost inflation:

> First, hospitals, unlike physicians, are not mobile and cannot follow population movements. In many areas of the country, populations have shifted away from neighborhood and communities in which hospitals are situated. While the Kennedy proposal might fill beds in hospitals in older neighborhoods and communities, it would probably exacerbate demand and raise costs in newer areas already short of hospitals beds.
>
> Second, the hospital industry has been scaling down operations to accommodate the reduced demand resulting from cost-containment efforts in both the public and private sectors. The increased demand from those obtaining the minimum ben-

efits will require the industry to begin to bid up wage rates in order to attract nurses and other health workers to hospitals.

Third, hospitals have reorganized in order to market outpatient services, such as outpatient surgery and home health care, the prices of which are not regulated by state or federal agencies. Revenue from these outpateint services is then used to subsidize losses from inpatient services, the prices of which are frequently regulated. It is unlikely that hospitals will optimize the mix of regulated and unregulated services to maximize revenue and that the increased general demand for unregulated services will boost prices.

REGIONAL POOLS

S. 1265 requires small employers to purchase insurance plans offered by a regional insurance pool. This is proposed to "reduced premium costs." In fact, however, regional pools will not lower insurance costs for small business. The two principal components of premium costs are claims payments and administrative expenses. One of the principal components of claims payment costs is medical inflation, which is not addressed by S. 1265. On the administrative end, S. 1265 will not eliminate the expense of insurance services for small businesses.

Administrative expenses, including claims processing, agent commissions and marketing costs, are all elements of the costs of coverage. There is also a difference ranging between 13% and 15% between the administrative expenses assessed large versus small employers. Creation of a regional pool does not alleviate this reality. According to insurance industry representatives, an insurance company will still need to interact with each of the small employers that participate in the pool to conform eligibility for benefits and for ongoing information on plan design. For example, one hundred small employers, each of which has fifty employees, will continue to place many more demands on the insurance carriers, or pool administrators, than one employer with 5,000 employees. Administrative costs will continue to be expensive and will not be eliminated by a mandate or by grouping the risks.

Premium costs for the plan offered by a regional insurer would be calculated under a community-rated basis for all employers. Blue Cross and Blue Shield provided the Committee with convincing evidence that, because participating regional insurers would not be allowed to set or adjust premiums for a particular group of employees or their families to reflect age, gender, or other factors relating to the projected or actual use of health services under the plan, the community rated regional pool would result in significant interstate subsidies. Employers and employees in lower cost states would be subsidizing employers in higher cost states. For example, the cost for health care for citizens in Vermont is 18 percent less than the average cost of care in the New England area. So, Vermont citizens who work for a small employer would have to pay as much as 18 percent more for their coverage. In New Hampshire, the average health care cost is 16.8 percent less than New England as a whole.

Utah's rates are 24 percent less than the average care for citizens in the mountain states region. In South Carolina, it is almost 25 percent less than the average care in the South Atlantic region. In Indiana it is 17 percent less than the average care in the East North Central region. Nonetheless, the citizens of these states will have to pay inflated premiums to compensate for the higher cost of health care in neighboring areas.

REAL ALTERNATIVES FOR THE UNINSURED

The fundamental problem in increasing individuals' access to care is the rising cost of health care, which is still growing at three times the rate of general inflation. Health insurance premiums rose at rates of 20–70 percent alone last year.

Much of this growth can be attributed to the explosion in medical liability costs. Joseph Califano, the Secretary of the Department of Health and Human Services during the Carter Administration, estimated that fear of malpractice lawsuits adds 35 percent to health care costs. A study by the AMA confirmed this estimate, finding that 80 percent of all doctors admit that they order many more medical tests than are really necessary. Some physicians do it to increase profits, but most order more tests in an effort to protect themselves from liability.

The inevitable consequence has been a diminution in access to quality health care. For example, at the very time the federal government is undertaking several new efforts directed at reducing infant mortality in this country, large numbers of physicians are deciding to stop delivering babies altogether. Even for those physicians who continue their practice, premiums are skyrocketing.

If we could save just a part of the resources which are being wasted because of medical malpractice, we could remedy the $8 billion uncompensated care problem in this country. We could solve it without raising taxes, without creating new federal programs and bureaucracies, and without adding new costs to employers.

For example, Dr. Gail Wilensky, from Project Hope, made the following comment:

> The United States already provides strong incentives to obtain employer provided insurance by excluding employer provided contributions from the employee's taxable income. This system has provided insurance for the vast majority of our working population. Similar incentives could and should be extended to the self-employed and sole proprietors, and assistance more than we offer now can be offered to small employers who wish to engage in pooling arrangements such as multiple employer trusts and the equivalent of a Taft-Hartley trust for non-unionized workers to help the employer with a high labor turnover.

The Health Insurance Association of America has proposed reforming Medicaid so that all families below the poverty index can be covered. Their proposal will cost the federal government $6 billion, but it will ensure coverage to about 18 to 20 million of these currently uninsured. The Robert Wood Johnson Foundation is looking at innovative approaches to provide private health insurance to the uninsured, several of which served as the model for Senator Quayle's legislative proposal. I believe the Committee could have demonstrated multiple ways to address the lack of access to health insurance. Congress should look at these initiatives very seriously. Such proposals include eleven projects: The use of efficiently managed care delivery systems to keep health care costs down; cutting premiums by limiting benefits; negotiating rates or provider discounts to reduce the premium payments; projects giving full or partial state subsidies for premiums; creating a multiple employer trust for small businesses that don't provide benefits; using state risk sharing pools or reinsurance; educating small employers on the need for health insurance, and helping them get information on available low-cost coverage for their workers.

States have also begun to react. Twenty-four states have expanded Medicaid eligibility to include additional pregnant women and children this year. Fifteen states have created special health insurance pools for high-risk individuals who cannot obtain coverage in the private market.

Because the problems of the uninsured are so diverse, it will require a combination of efforts—restraining costs, promoting healthy lifestyles, and reducing some barriers that currently block Americans from getting served. Trying to impose a singular solution onto every employee as S. 1265 would do, will simply not work and is really little more than a backdoor attempt to begin the transformation toward national health insurance.

CONCLUSION

There is little dispute on the Committee that there are 37 million Americans who lack health insurance. Similarly, there is consensus that the cost associated with their lack of insurance is approximately $8 billion a year. To solve this problem, the majority proposes a solution that will cost American workers between $28 billion and $100 billion a year, eliminate between 60,000 and 1 million jobs, feed the current inflated cost of health care, force citizens of states with low health care costs to underwrite their less frugal neighbors, deny employees the opportunity to choose the kind of benefits they would include in their health care package for all workers regardless of their economic status. And, there is no guarantee that their proposal will solve the underlying problem.

In sum, the Committee has failed to find a realistic, effective and equitable solution to this problem. It should be asked to try again, to look at a wider variety of proposals, to seek a solution that does not eliminate hundreds of thousands of jobs, to find a remedy that does not stifle growth, flexibility and competitiveness, and to ensure small businessmen and women they will not be driven out of business by Congressional whim.

We also ask that opposing views from the Department of Labor, Department of Justice, and Department of Health and Human Services be included.

ORRIN G. HATCH.

We join in supporting the dissenting views on S. 1265 by Senator Orrin G. Hatch.

STROM THURMOND.
THAD COCHRAN.
DAN QUAYLE.
GORDON J. HUMPHREY.

U.S. Department of Justice,
Office of Legislative and Intergovernmental Affairs,
Washington, DC, November 13, 1987.

Hon. Edward M. Kennedy,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: This letter is in response to your request for the views of the Department of Justice on S. 1265, the "Minimum Health Benefits for all Workers Act of 1987." S. 1265 would require that all employers in the United States provide their employees with a minimum federally-prescribed package of health insurance benefits. It would preempt all State regulation of employee health insurance benefits. The Department strongly opposes the bill on economic policy and federalism grounds.

A. MINIMIZING GOVERNMENT INTERFERENCE IN THE PRIVATE SECTOR

This Administration firmly believes that, as a general matter, the terms and conditions of private employment should be decided in the private marketplace, without unnecessary interference by government. The decision as to what employee health insurance benefits to provide is one properly left to the affected employees and employers. They can best gauge the benefits and corresponding costs of such employee benefits. S. 1265 inappropriately substitutes government for private decisionmaking in this area.

Requiring firms to provide health insurance coverage for all workers would constitute a tax on the use of labor. Such a tax might induce some firms and individuals to substitute capital for labor, thereby decreasing employment possibilities and contributing to unemployment. This tax on labor would further distort the efficient allocation of resources, thereby undermining economic efficiency. In short, the health insurance benefits requirement would prove economically harmful.

Mandating a minimum level of health insurance benefits could also prove economically undesirable for many workers. It would, for example, limit the ability of employees to maximize their own compensation and require those employees who have no use for health benefits to subsidize those employees who have. In employment negotiations, employees may be forced to sacrifice wages or other benefits that they value more highly than the statutorily-mandated level of health benefits. Finally, to the extent they are able to do so, employers can be expected to pass the increased cost of these benefits on to consumers in the form of higher prices or reduced quality of the goods and services they produce.

In addition, the bill would have a disproportionate impact on small businesses, which tend to be the firms that cannot now afford to provide health insurance benefits. Small businesses in this country account for more than 50 percent of the 10 million jobs that have been created during the past four years alone. Requiring small businesses to provide these benefits would restrict their ability to employ more workers in the future.

B. FEDERALISM OBJECTIONS

1. In general

For the reasons set forth above, the subject matter of S. 1265 is inappropriate for government regulation. Even if regulation is believed necessary, however, there is no justification for a national "solution" in this area of traditional State responsibility. Each State should remain free to address the particular health care and employee benefit needs and conditions that exist in that State.

This Administration's strong commitment to the principles of federalism requires that it oppose federal government intervention in matters that traditionally have been the responsibility of the States, and in which there is no overriding need for national policy uniformity. The States are charged with protecting the health, safety, and welfare of their citizens. The are in the best position to discern the conditions, needs, and desires of their citizens on these issues, and they have the expertise to enact laws to address those concerns. While some States may conclude that employee health insurance benefits are, on balance, appropriate subjects for mandatory rules, others may not.

We see no need for a uniform national rule on this subject. Given the difficulty of analyzing the relevant costs and benefits, and determining the appropriate level of health insurance benefits, this appears to be an area most appropriately left to the States, allowing them to serve as policy laboratories and to experiment with a variety of approaches to the perceived problems. We do not believe, in sum, that the federal government should intrude on the prerogatives of the States in this area.

We are also concerned about whether the subject matter of this legislation is sufficiently within interstate commerce, and thus within Congress' constitutionally delegated responsibility. We believe that S. 1265 is at the outer reaches of the judicial precedent which permits Congress to legislate over matters merely "affecting interstate commerce." Thus, although we have concluded on the basis of this existing precedent that S. 1265 would be held constitutional, we also believe as a matter of federalism policy that such a sweeping exercise of congressional authority would not be justified in light of both the traditional role played by the States in this area and the attenuated nature of Congress' commerce power interests.

2. Enforcement against State and local governments

Because of the general grounds for opposing S. 1265 that have been discussed above, we do not believe it is necessary to comment in detail on specific provisions of the bill. The bill's application to State and local governments, however, warrants particular attention. The bill would amend the Public Health Service Act by adding section 2301(b)(1), which would condition grants to State and local governments under that Act on compliance with the bill's requirements. That condition would thus be a "crossover sanction" (i.e., tying a regulatory requirement to a grant where the requirement has little or no relationship to the purpose of the grant). A requirement that the States provide health insurance benefits to their employees is at best only remotely related to the purposes of the quite substantial federal grants to the States to support their public health activities. See 42 U.S.C. 243–247d.

This Administration is concerned, as a matter of federalism policy, about conditions on federal grants that are only tangentially related or totally unrelated to the purpose of the grant program. In light of the condition sustained in *South Dakota* v. *Dole,* 107 S. Ct. 2793 (1987) (conditioning federal highway grants on State enactment of a 21-year-old minimum drinking age), we recognize that it is likely that the Court would find, for constitutional law purposes, that public health grants are sufficiently related to employee health insurance benefits. As a matter of federalism policy, however, we urge that Congress not tie these very different matters together.

Finally, Congress should recognize that in general this legislation would have the effect of increasing State and local payroll costs and substantially reducing the flexibility of State and local government decisionmaking on personnel matters. It would thus limit the authority of State and local governments to manage their own affairs (i.e., to provide needed government services at a reasonable cost, and on terms that are mutually acceptable to voters and workers). In light of *Garcia* v. *San Antonio Metropolitan Transit Authority,* 469 U.S. 528 (1985), it is clear that the task of safeguarding the sovereignty of the States has principally fallen to the political branches of the federal government. We do not believe that Congress would be faithful to this task if it applied the requirements of S. 1265 to State and local government employers.

C. CONCLUSION

For the reasons stated above, the Department of Justice strongly opposes enactment of S. 1265. The Office of Management and Budget has advised this Department that there is no objection to the submission of this report to the Congress and that enactment of S. 1265 would not be in accord with the program of the President.

Sincerely,

THOMAS M. BOYD
(For John R. Bolton, Assistant Attorney General).

U.S. DEPARTMENT OF LABOR,
SECRETARY OF LABOR,
Washington, DC, February 11, 1988.

Hon. EDWARD KENNEDY,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This letter is in response to your request for our views on S. 1265, the Minimum Health Benefits for All Workers Act of 1987. For the reasons stated below, the Department of Labor opposes the provisions of S. 1265.

The efficient and effective operation of the employer-sponsored health insurance system is important to improving the health and quality of life of American workers, and therefore of vital concern to the Department of Labor. Under the Employee Retirement Income Security Act (ERISA), the Department administers a framework of laws which regulate a voluntary system of employer-sponsored benefit plans under certain federal standards intended to ensure that participants and beneficiaries receive the benefits they are promised. Proposals to mandate the benefits provided under the employer-sponsored health benefits system would affect not only these laws, but would also significantly affect our public policies relating to other efforts designed to improve the health and education of our nation's workforce in a flexible and competitive economy.

S. 1265 would require employers subject to the Fair Labor Standards Act, including any State or political subdivision, to enroll their employees who work more than 17.5 hours per week and their families in a health benefit plan that provides certain specified benefits. Under the bill, health plans would have to conform to specified limits on deductibles and coinsurance rates. Employers would be required to pay at least 80 percent of the premium, except for low-wage employees for whom the employer would have to pay all of the premium. In addition, ERISA would be amended to expand preemption beyond its current broad terms, so as to exempt employer health plans which are funded through insurance contracts or policies from state mandated health benefits laws. Regional insurance markets would be established and administered by the Federal government to provide plans for small employers without coverage who cannot afford individually designed plans.

The Department of Labor strongly supports efforts to encourage employer-sponsored health insurance for uninsured and underinsured workers. The policy implications of this proposal, however, are far reaching and would have a dramatic effect on labor relations and the economy. This proposal would extend health coverage to over 20 million workers and their dependents who are currently uninsured; would mandate employer-sponsored coverage for another significant number of workers and dependents currently insured under individual policies; and would require some employers to offer a benefit package greater than that which they currently offer to an indeterminant number of workers.

The bill prescribes a set of benefits which may not be appropriate for many workers. While the bill provides some flexibility in the design of the minimum benefit package, these provisions are likely to be very cumbersome to regulate and expensive to administer. We are concerned that this legislation would impose the rigidities and costs of a mandatory health insurance system on our voluntary employee benefits system, with grave consequences for employee benefits policy. Further, we believe that a minimum health benefit plan would constitute an unwarranted instrusion into the collective bargaining process. This legislation could ultimately be detrimental to the workers it was intended to benefit.

The impact on the labor market of the proposal is likely to be substantial. The effect of imposing new costs on the workplace would be to create barriers to the employment of low-wage and part-time workers, including the young and minorities. However, unlike the minimum wage, employee health costs are unpredictable and may be substantial. Thus, by mandating full health coverage for those who work at low wages or part-time, the bill would cause a substantial and uncontrollable increase in the labor cost of such workers. In time, we could expect a decline in the employment of these workers and in their real wages, as well as the creation of other labor market distortions.

Because the costs of employee health insurance may vary by firm size, geographical region, and other factors, this legislation could result in a shifting of production costs between various sectors of the eonomy and types of firms. Of particular concern would be the impact on small businesses, which up to now have been the major source of employment growth and which are most likely to be adversely affected by this proposal.

Aside from its general economic impact, this legislation has specific implications for the programs administered by the Department of Labor. For example, subject to certain exceptions, the current ERISA preemption provisions generally supersede state laws relating to any employe benefit plan, including employer-sponsored health plans, while maintaining the traditional state function of regulating the business of insurance. The current preemption language has enabled the efficient operation of the voluntary employee benefit system while maintaining the integrity of state insurance law.

S. 1265 would extend this preemption to state laws regulating, or otherwise providing any requirement relating to, contracts or policies issued to or under a health plan established pursuant to this bill.

We are also opposed to this legislation because of the significant adverse consequences we believe it would entail for an already heavily burdened employee benefits plan community. The extent of this regulation is already such that Reorganization Plan No. 4 of 1978 was implemented to address the multiple jurisdictions and overlapping regulation which currently exist.

While we share your concern about expanding health coverage for uninsured and underinsured workers, we do not believe that mandating coverage through the workforce is the right way to ensure such coverage. We are deeply concerned about the potential effects of this proposal on the economy. We believe that any legislation in this area should be evaluated carefully against the need to sustain a healthy rate of growth in employment, the creation of an educated and skilled workforce, and the improvement of our competitiveness. While we believe that the goal of ensuring health care protection for the uninsured and underinsured worker is praiseworthy, the potential effects of this specific proposal would be highly undesirable. For these reasons, we recommend that the bill not be favorably considered.

The Office of Management and Budget advises that there is no objection to the submission of this report to the Congress and that enactment of S. 1265 would not be in accord with the program of the President.

Sincerely,

ANN MCLAUGHLIN.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, February 16, 1988.

Hon. EDWARD M. KENNEDY,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This is in response to your request for a report on S. 1265, a bill "To amend the Public Health Service Act and the Fair Labor Standards Act of 1938 to provide minimum health benefits for all workers in the United States."

In summary, we are opposed to this bill. While agreeing that health insurance coverage should be more widely available, we believe that the proposed solution would do more harm than good. The bill would establish a broad new Federal mandate which would create a sweeping new regulatory role for the Federal Government. The Act has been estimated to increase health insurance costs by $27 billion, of which over 90 percent would be paid by employer contributions. In our view, the problem of lack of insurance for workers and their dependents can and should be addressed in a more targeted manner and in a fashion that recognizes progress and potential at the State, local, and employer level.

S. 1265 would require all employers to enroll employees working more than 17.5 hours per week and their families in health benefit plans providing a range of basic benefits. Health plans would have to conform to specified limits on deductibles, coinsurance rates, and annual cost sharing amounts (or offer actuarially equivalent benefits). Employers would be required to pay a substantial portion of the premium cost, and, in particular, premium contributions would be waived altogether for low-wage employees. The Employee Retirement Income Security Act of 1974 (ERISA) would be amended to broaden the Federal preemption of State regulation of employer-provided health insurance. Regional insurance markets administered by the Federal Government would be established. Small employers without health plans would be required to obtain coverage for their employees through qualified regional insurers.

The consequences of S. 1265 span a wide range of issues. This letter reviews those consequences related to health policy. Several of the points enumerated below are discussed more fully in an enclosure.

Federal regulation of all employer-sponsored health plans

Although S. 1265 would have its primary impact on employers that do not offer employee health insurance, in fact, all insurance contracts and policies issued to or under a health benefits plan would be brought within the purview of Federal regulation and Congressional political control.

Federal regulations would be required to enforce standards of sufficiency prescribed in the bill. For reasons noted in an addendum to this letter, we foresee recourse to a crude dollar floor test that would largely stifle employer efforts to contain employee health costs.

Politicization of health plan design and administration

The proposed legislation is likely to bring political pressures to bear on private-sector health plan design and administration. Congress, having supplanted State regulators, would be likely to repeat the experience of the States, expanding benefits over time (the extra cost would be off-budget) to levels far beyond what employers and consumers would voluntarily choose in an unregulated market.

Tax increases for government at all levels

The proposal would mandate benefit expansion and higher employer contributions not only for private-sector employers, but for Federal, State and local governments as well. Tax increases would be the likely method of financing expanded government outlays for employee benefits. Federal employee benefit costs would increase by an estimated $300 million.

High-risk experimentation on a national scale

Although we recognize the need to improve small business' access to health insurance, we have no reason to think that the arbitrary scheme of regional markets proposed by S. 1265 is the right plan or even a feasible one. Considering how little is known about market mechanisms such as the one proposed, we believe that development of small-business insurance markets should follow an incremental, State-oriented approach.

Other legislation should be given time to take effect

The Tax Reform Act of 1986 imposes new rules preventing companies from offering generous health benefits to higher-paid employees (and their dependents) while providing only meager benefits to lower-paid workers. When they are implemented, these rules should ameliorate much of the problem associated with the lack of dependents' coverage under employer-sponsored insurance. This legislation should be given time to work.

States are making progress

States are already implementing programs designed to make health insurance more affordable for business and individuals. Beginning with varying types of risk pools for "uninsurables," States have now begun to experiment with more ambitious measures to help citizens obtain health insurance. We encourage constructive State initiatives in this area, illustrated by some of the provisions in S. 2027 recently introduced by Senator Quayle. Given this foundation, the proper Federal role would seem to be to encourage progress along this path consistent with current law, for example by focusing attention on unnecessary benefits mandated by States for employer-provided health insurance, and by pointing out how the higher premiums resulting from those mandates discourage employers from offering health insurance.

In summary, we believe S. 1265 would impose an unduly intrusive and centralist solution, one wholly disproportionate to the dimensions of the problem being addressed. The proposal would open the door to broad new Federal regulation of the private health care sector, exacerbate health care inflation, and upset settled wage and benefit arrangements, all to address a problem that, though complex, is limited in scope and amenable to treatment with more precisely-focused measures at the State level.

We therefore strongly recommend that the bill not be favorably considered.

We are advised by the Office of Management and Budget that enactment of S. 1265 would not be in accord with the program of the President.

Sincerely,

OTIS R. BOWEN, M.D.,
Secretary.

S. 1265: ADDITIONAL COMMENTS

The following comments elaborate on points made under corresponding headings in the letter.

Federal regulation of all employer-sponsored health plans

Regulation under S. 1265 would be primarily concerned with assuring that employers provided the mandated coverage. To allow for flexibility in plan design, the bill permits benefit and cost sharing specifics to fall short of prescribed levels as long as a plan is equivalent in overall "actuarial benefits." We think it likely that this approach would prove unworkable in the face of real-world plan diversity and discordant motivations of some employers. The most likely outcome would be that regulators would resort to testing plan adequacy according to a simple dollar spending criterion. Plans would be in compliance if an employer's annual per-employee outlay met or exceeded a set minimum.

Although this mode of regulation is relatively straightforward, we would expect it to stifle incentives that now encourage employers to seek—and carriers to offer—cost-reducing innovations in health plan design and administration. The result would be to weaken cost containment progress in the private sector.

Politicization of health plan design and administration

As Federal agencies assumed regulatory and enforcement responsibilities, Congress would itself undertake a corresponding oversight role in the presence of normal political pressures. We foresee Congress applying its legislative powers to expand control over details of employer plan benefits structure, organization, and financing. The predictable outcome of this process would be a more intrusive Federal presence in management decisions over delivery, technology, price, and quality of medical care.

Tax increases for government at all levels

The overall Federal fiscal impact would depend on the relative strength of two other effects, (1) a downward adjustment in cash wage levels to compensate for higher mandated benefits, and (2) a reduction in public outlays as some uncompensated costs were assumed by mandated insurance. Under assumptions made by Congressional Budget Office analysts, these two effects are estimated to offset each other.

ADDITIONAL MINORITY VIEWS

We would like to offer additional observations regarding S. 1265 and the overall problem of the uninsured worker.

THE PROBLEM OF THE UNINSURED WORKER IS VALID

We are all aware that a growing number of Americans either have no health insurance or are inadequately insured. According to population data recently compiled by the Employee Benefit Research Institute, the number of people with no health insurance coverage of any kind—35 million in 1985—has grown nearly 15 percent since the 1982 economic recession. Most of this increase—nearly three-fourths—occurred among workers; the number of workers without health insurance has grown by more than 22 percent since 1982. There is no doubt that the problem of the uninsured worker and his dependents, must be addressed by our society.

However, the uninsured are a heterogenous group, needing a variety of solutions. Although two-thirds of all uninsured are somehow related to the workplace, even this segment has various economic characteristics. One solution cannot address all of their needs. There is clear evidence that the solution endorsed by the majority—to require all employers to provide what is labelled as "basic minimum" health insurance—would put small marginal businesses and low-wage, unskilled workers at risk of economic displacement. For these reasons, we cannot support S. 1265; however, we believe there is a legitimate need to address the problem of the uninsured in our country.

S. 1265 IS BAD FOR BUSINESS AND WORKERS

Overall cost to employers

We have grave doubts that mandatory employee health insurance will solve the problems of the working uninsured. We are most concerned about the cost to employers and the unemployment impact of this measure.

A study released recently by Robert R. Nathan Associates indicated that an employer's per policy cost of providing the Kennedy health insurance proposal would be between $1078 to $1274 for single worker policies and between $2737 to $3234 for family policies. Total costs for all employers of providing this insurance would be between $33 and $39 billion in 1988—and this cost projection may be 20% too low because the study excludes those workers not covered by the minimum wage.

In fact, there is new evidence that all cost estimates to date of the Kennedy health insurance bill are unrealistic. Another recent survey released by A. Foster Higgins & Co., shows that health benefit costs climbed to an average of $1,985 per employee in 1987, increasing an average of $128 per employee or 7.9 percent over 1986 costs. (The Committee should note that the survey found that New England employers experienced the largest percentage increase in health benefit costs, over 11% from the previous year and over $2,000 per employee.)

The Foster Higgins survey also showed that nearly one-fifth of the 2,016 public and private sector employers surveyed reported cost increases of 20 percent or more, while 6 percent of surveyed employers experienced increases in excess of 30 percent. These dramatic, real life, health benefit costs and inflation data should be considered seriously before forcing small marginal employers to assume the lion's share of their employee's health benefit costs.

The impact on employment

The mandatory minimum health benefits bill is only one of several employer mandates currently under consideration by this Committee. The majority have also indicated that they will seek passage this year of S. 837, a bill to increase the minimum wage from $3.35 to $4.65 in 1990. When combined with the minimum wage increase, the mandatory health benefit bill will increase the hourly wage for full-time minimum wage workers by 48.4% and for part-time workers (those working 1000 hours annually) by 67.8%.

In fact, this cost increase could be even higher, since it was based on estimates of S. 1265 as originally introduced. During Committee mark-up of the bill, inclusion of expensive mental health benefits were approved.

It is significant to note Congress' experience with the Medicare catastrophic bill, currently in conference. Originally intended to cover unlimited hospital stays and Medicare-approved out-of pocket expenses above $2,000, the measure now proposes to provide respite care and expanded home health and hospice benefits, as well as traditionally expensive and inflationary drug coverage. Surely, Congress will not be able to resist the same pressure from provider and consumer groups as it considers S. 1265. We think it is safe to say that the Minimum Health Benefits bill will not remain "minimum" in the long run.

The Congressional Budget Office has estimated that the combined effect of S. 837 and S. 1265 would be a loss of some 500,000 jobs—mainly among younger workers. In other words, the overall unemployment rate would increase from 5.8% to 6.3%. The youth unemployment rate would increase from the current 12.3% to 14.65%. The impact on minority youth unemployment would be even worse.

It is ironic that this proposal designed to benefit low wage workers would force them to lose their jobs. It is also ironic that this segment of our population is among the most chronically uninsured: they are most likely to work for the types of businesses which do not provide health insurance, and because they work, they do not qualify for Medicaid.

Also, another adverse employment consequence not intended by the authors of S. 1265 is that employers simply can reduce the number of hours employees are required to work below the minimum requirement of 17½ hours per week in order to avoid the expense of mandatory insurance. Besides offering no assurance that they will receive health insurance under S. 1265, low wage and less skilled workers might face shorter work weeks and thus less pay.

PROBLEMS WITH THE REGIONAL POOL PROVISIONS

S. 1265 not only requires all employers to provide a defined set of health benefits to their employees, but also requires small employers who have never provided health coverage prior to enactment of the mandate to purchase insurance from a "regional pool" or carrier. HHS is required to designate 6 to 8 regions across the country for which insurance carriers would compete to provide the insurance to pool participants.

Although these pools are intended to provide low cost insurance to small employers, who according to the majority views face insurance costs 10% to 40% higher than those for larger employers, we feel that this concept is doomed to failure for mechanical as well as political reasons.

Interstate subsidy

Because premiums charged by a regional pool insurer would have to be calculated on a community-rated basis—meaning everyone in the pool would pay the same per person premium—employers and employees in lower cost states would be subsidizing employers of high cost states.

This has been a hotly debated issue under the Medicare DRG system for hospital payments with respect to the movement of payment based on regional rates to national rates. Recent data shows that within these Medicare payment regions, many Labor and Resources Committee members' home states have health costs far below the regional average. For example, in the Pacific region, the states of Washington and Hawaii fall 26.3% and 30.7%, respectively, below the average, clearly subsidizing California, whose costs are 10.5% above the regional average.

The state of Indiana, in the East North Central region, has costs 17.3% below the average, subsidizing Illinois, who is 8.9% average the regional average.

This data, supplied to the Committee by the Blue Cross and Blue Shield Association, illustrates that states would experience similar cross subsidies under S. 1265. Medicare data are relied upon by researchers for trends in general health care costs because they are the largest, most consistently gathered, audited, and edited health care data available.

Members of the Senate should keep this critical issue in mind when it considers S. 1265. Although the pools are intended to afford small employers access to low cost group rates, we are afraid it may have the unintended result of forcing employers in states with more efficient health care systems to subsidize that of less efficient states. The smallest, most vulnerable employers, in particular, should not be forced to bear this burden.

Community rating will not keep down premium costs

The majority views indicate that regional pooling will "maximize effective competition and reduce administrative and sales costs". We believe these claims are insupportable; on the contrary, there is adequate evidence to suggest that these community rated pools will be highly inflationary.

First, there is little or no evidence that by allowing a choice of regional insurance carriers, such as PPOs, HMOs, and indemnity plans, competition among these plans will keep down health premium costs.

We need only to look at the Federal Employee Health Benefit Program (FEHBP), with a choice of some 480 plans, to see that employee choice is not working to contain health costs. An April 30, Washington Post article quotes Office of Personnel Management Director, Constance Horner, as saying that competition under FEHBP is a "myth". A consulting firm hired to review the performance of the program found that instead of competing to offer the best benefits at the lowest cost, FEHBP plans compete to attract the healthiest risks and repel the sick. Here, "consumer choice" has given rise to such extreme adverse selection that the FEHBP experienced average premium increases last year of 31%.

Also, there is no evidence that by simply prohibiting all forms of underwriting this will make premiums affordable for small employers. Such underwriting practices are pre-existing condition waiting periods and basic risk classification for age and gender are typically used by insurers to discourage adverse selection, thus helping to contain plan costs. Critically, the pool will contain the worst risks in the marketplace—employers with less than 25 employees, employers with no health insurance experience, and those employers otherwise unable to buy it. Those employers lucky enough to leave the pool will be those with healthy enough workers to buy a cheaper product in the regular marketplace, thus leaving the pool with an even worse mix of lives from which to base a community rate.

AN ALTERNATIVE PROPOSAL FOR THE UNINSURED

Although we applaud the distinguished Chairman of this Committee for trying to address the problem of the uninsured, we think it is dangerous to impose an untried national solution on employers. Congress should not hastily approve this measure without first estimating its potential for success. Only one state, Hawaii, has such a mandate in place, and to date there has been no thorough appraisal of this system in addressing that state's uninsured.

It is important to note that several states have embarked on a variety of initiatives on their own. The Robert Wood Johnson Foundation has funded 15 projects for the uninsured (although they have recently announced that the Foundation will be focusing future funding on other health care priorities). These efforts are based on the theory that alternative strategies for the uninsured need to be tried. These parallel efforts clearly indicate the lack of any clear consensus on the most appropriate approach the complex problem of the uninsured.

We think that the Federal government should provide coherence and oversight to these state efforts by sponsoring a series of test solutions and studies of solutions for the uninsured. The government first should gather data on the successes and failures of these varied approaches, before imposing a national solution. On February 2, Senator Quayle introduced S. 2027, which would do just that.

S. 2027 would authorize a pilot project setting up a Medicaid buy-in for poor and near-poor workers; one to waive state mandated benefit laws to permit the development of a more affordable insurance package for small employers; authorize a study of the Hawaii prepaid health plan; authorize grants to test the provision of broader tax incentives for the self-insured; authorize projects to test the impact of eliminating state regulatory barriers for developing multiple employer health plans; and authorize a study of the feasibility of health insurance information brokering services for small businesses.

Finally and most importantly, S. 2027 would require the Secretary to undertake evaluations of these projects as well as other selected projects that have been undertaken by the states and private entities and foundations. The purpose of such evaluations would be to examine some of the practical effects of the pilots and to assess the feasibility of expanding these efforts to broader populations and geographic areas. These evaluations should provide us with the information we need to address the complex problem of the uninsured.

The experience of pilot projects in the states have been instrumental in the current debate on Federal welfare reform. Also, the success of state pilots were key to the establishment of the Medicare Prospective Payment System, approved in 1983. This is a more realistic way for finding a solution for the uninsured, rather than simply debating the merits of the mandatory health insurance bill for the next several years. While Congress struggles to find a consensus approach for the uninsured, we could be gathering data and getting experience with real solutions.

DAN QUAYLE.
THAD COCHRAN.
ORRIN G. HATCH.

XII. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change in proposed is shown in roman):

Public Health Service Act

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

Part A—Research and Investigation

* * * * * * *

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

Sec. 305. (a)–(g) * * *

(h) In each fiscal year, seven and one-half percent of the amount made available under section [2313] *2413* for such fiscal year for evaluations shall be made available to the Assistant Secretary for Health to conduct or support (by both grants and contracts) through the Center, evaluations of health services and health care technology which evaluations are not being conducted or supported under this section or section 304. In administering this subsection, the Secretary shall assure that the amount to be made available in any fiscal year is seven and one-half percent of the maximum amount authorized to be made available under section [2313] *2413* in such fiscal year.

* * * * * * *

TITLE IV—NATIONAL RESEARCH INSTITUTES

* * * * * * *

Part D—National Library of Medicine

Subpart 1—General Provisions

PURPOSE, ESTABLISHMENT, AND FUNCTIONS OF THE NATIONAL LIBRARY OF MEDICINE

Sec. 465. (a)–(e) * * *

(f) Section [2301] *2401* shall be applicable to the acceptance and administration of gifts made for the benefit of the Library or for carrying out any of its functions, and the Board of Regents shall make recommendations to the Secretary relating to establishment within the Library of suitable memorials to the donors.

* * * * * * *

PART G—GENERAL PROVISIONS

INSTITUTIONAL REVIEW BOARDS; ETHICS GUIDANCE PROGRAM

SECS. 491-496 * * *

GIFTS

SEC. 497. The Secretary may, in accordance with section [2301] *2401,* accept conditional gifts for the National Institutes of Health or a national research institute or for the acquisition of grounds or for the erection, equipment, or maintenance of facilities for the National Institutes of Health or a national research institute. Donations of $50,000 or over for the National Institutes of Health or a national research institute for carrying out the purposes of this title may be acknowledged by the establishment within the National Institutes of Health or a national research institute of suitable memorials to the donors.

* * * * * * *

TITLE XXIII—MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

HEALTH BENEFITS

SEC. 2301. (a) IN GENERAL.—Each employer shall, in accordance with title III of the Minimum Health Benefits for All Workers Act of 1988, enroll each of its employees and their families in a health benefit plan.

(b) ENFORCEMENT.—

(1) INELIGIBILITY FOR ASSISTANCE.—An employer that is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision and that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall not be eligible to receive a grant, contract, loan, or loan guarantee under this Act.

(2) GENERAL ENFORCEMENT PROVISIONS.—Any employer that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Minimum Health Benefits for All Workers Act of 1988.

(c) DEFINITIONS.—The terms used in this section have the meanings prescribed for the terms by section 303 of such Act.

TITLE [XXIII] *XXIV*—MISCELLANEOUS

GIFTS

SEC. [2301] *2401.* (a) The Secretary is authorized to accept on behalf of the United States gifts made unconditionally by will or otherwise for the benefit of the Service or for the carrying out of any of its functions. Conditional gifts may be so accepted if recommended by the Surgeon General, and the principal of and income from any such conditional gift shall be held, invested, reinvested, and used in accordance with its conditions, but no gift shall be accepted which is conditioned upon any expenditure not to be met therefrom or from the income thereof unless such expenditure has been approved by Act of Congress.

(b) Any unconditional gift of money accepted, pursuant to the authority granted in subsection (a) of this section, the net proceeds from the liquidation (pursuant to subsection (c) or subsection (d) of this section) of any other property so accepted, and the proceeds of insurance on any such gift property not used for its restoration, shall be deposited in the Treasury of the United States and are hereby appropriated and shall be held in trust by the Secretary of the Treasury for the benefit of the Service, and he may invest and reinvest such funds in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. Such gifts and the income from such investments shall be available for expenditure in the operation of the Service and the performance of its functions, subject to the same examination and audit as is provided for appropriations made for the Service by Congress.

(c) The evidences of any unconditional gift of intangible personal property, other than money, accepted pursuant to the authority granted in subsection (a) of this section shall be deposited with the Secretary of the Treasury and he, in his discretion, may hold them, or liquidate them except that they shall be liquidated upon the request of the Secretary, whenever necessary to meet payments required in the operation of the Service or the performance of its functions. The proceeds and income from any such property held by the Secretary of the Treasury shall be available for expenditure as is provided in subsection (b) of this section.

(d) The Secretary shall hold any real property or any tangible personal property accepted unconditionally pursuant to the authority granted in subsection (a) of this section and he shall permit such property to be used for the operation of the Service and the performance of its functions or he may lease or hire such property, and may insure such property, and deposit the income thereof with the Secretary of the Treasury to be available for expenditure as provided in subsection (b) of this section: *Provided*, That the income from any such real property or tangible personal property shall be available for expenditure in the discretion of the Secretary for the maintenance, preservation, or repair and insurance of such property and that any proceeds from insurance may be used to restore the property insured. Any such property when not required for the operation of the Service or the performance of its functions may be liquidated by the Secretary, and the proceeds thereof deposited with the Secretary of the Treasury, whenever in his judgment the purposes of the gifts will be served thereby.

USE OF IMMIGRATION STATION HOSPITALS

SEC. [2302] *2402*. The Immigration and Naturalization Service may, by agreement of the heads of the departments concerned, permit the Public Health Service to use hospitals at immigration stations for the care of Public Health Service patients. The Surgeon General shall reimburse the Immigration and Naturalization Service for the actual cost of furnishing fuel, light, water, telephone, and similar supplies and services, which reimbursement shall be covered into the proper Immigration and Naturalization Service appropriation, or such costs may be paid from working funds established as provided by law, but no charge shall be made for the expense of physical upkeep of the hospitals. The Immigration and Naturalization Service shall reimburse the Surgeon General for the care and treatment of persons detained in hospitals of the Public Health Service at the request of the Immigration and Naturalization Service unless such persons are entitled to care and treatment under section 322(a).

MONEY COLLECTED FOR CARE OF PATIENTS

Sec. [2303] *2403.* Money collected as provided by law for expenses incurred in the care and treatment of foreign seamen, and money received for the care and treatment of pay patients, including any amounts received from any executive department on account of care and treatment of pay patients shall be covered into the appropriation from which the expenses of such care and treatment were paid.

TRANSPORTATION OF REMAINS OF OFFICERS

Sec. [2306] *2406.* Appropriations available for traveling expenses of the Service shall be available for meeting the cost of preparation for burial and of transportation to the place of burial of remains of commissioned officers, and of personnel specified in regulations, who die in line of duty. Appropriations available for carrying out the provisions of this Act shall also be available for the payment of such expenses relating to the recovery, care, and disposition of the remains of personnel or their dependents as may be authorized under other provisions of law.

GRANTS TO FEDERAL INSTITUTIONS

Sec. [2307] *2407.* Appropriations to the Public Health Service available under this Act for research, training, or demonstration project grants or for grants to expand existing treatment and research programs and facilities for alcoholism, narcotic addiction, drug abuse, and drug dependence and appropriations under title VI of the Mental Health Systems Act shall also be available, on the same terms and conditions as apply to non-Federal institutions, for grants for the same purpose to Federal institutions, except that grants to such Federal institutions may be funded at 100 per centum of the costs.

TRANSFER OF FUNDS

Sec. [2308] *2408.* For the purpose of any reorganization under section 202, the Secretary, with the approval of the Director of the Bureau of the Budget,[1] is authorized to make such transfers of funds between appropriations as may be necessary for the continuance of transferred functions.

---

[1] Bureau of the Budget is now the Office of Management and Budget.

AVAILABILITY OF APPROPRIATIONS

SEC. [2309] *2409.*—Appropriations for carrying out the purposes of this Act shall be available for expenditure for personal services and rent at the seat of Government; books of reference, periodicals, and exhibits; printing and binding; transporting in Government-owned automotive equipment, to and from school, children of personnel who have quarters for themselves and their families at stations determined by the Surgeon General to be isolated stations; expenses incurred in pursuing, identifying, and returning prisoners who escape from any hospital, institution, or station of the Service or from the custody of any officer or employee of the Service, including rewards for the capture of such prisoners; furnishing, repairing, and cleaning such wearing apparel as may be prescribed by the Surgeon General for use by employees in the performance of their official duties; reimbursing officers and employees, subject to regulations of the Secretary, for the cost of repairing or replacing their personal belongings damaged or destroyed by patients while such officers or employees are engaged in the performance of their official duties; and maintenance of buildings of the National Institutes of Health.

UNAUTHORIZED WEARING OF UNIFORMS

SEC. [2310] *2410.*—Except as may be authorized by regulations of the President, the insignia and uniform of commissioned officers of the Service, or any distinctive part of such insignia or uniform, or any insignia or uniform any part of which is similar to a distinctive part thereof, shall not be worn, after the promulgation of such regulations, by any person other than a commissioned officer of the Service.

ANNUAL REPORT

SEC. [2311] *2411.*—The Surgeon General shall transmit to the Secretary, for submission to the Congress at the beginning of each regular session, a full report of the administration of the functions of the Service under this Act, including a detailed statement of receipts and disbursements.

MEMORIALS AND OTHER ACKNOWLEDGMENTS

SEC. [2312] *2412.* The Secretary may provide for suitably acknowledging, within the Department (whether by memorials, designations, or other suitable acknowledgments), (1) efforts of persons who have contributed substantially to the health of the Nation and (2) gifts for use in activities of the Department related to health.

EVALUATION OF PROGRAMS

SEC. [2313] *2413.* Such portion as the Secretary may determine, but not more than 1 per centum, of any appropriation for grants, contracts, or other payments under any provision of this Act, the Mental Health Systems Act, the Act of August 5, 1954 (Public Law

568, Eighty-third Congress),[1] or the Act of August 16, 1957 (Public Law 85-151),[1] for any fiscal year beginning after June 30, 1970, shall be available for evaluation (directly, or by grants or contracts) of any program authorized by this Act or any of such other Acts, and, in the case of allotments from any such appropriation, the amount available for allotment shall be reduced accordingly.

CONTRACT AUTHORITY

SEC. [2314] *2414*. The authority of the Secretary to enter into contracts under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.

RECOVERY

SEC. [2315] *2415*. (a) If any facility with respect to which funds have been paid under the Community Mental Health Centers Act (as such Act was in effect prior to October 1, 1981) is, at any time within twenty years after the completion of remodeling, construction, or expansion or after the date of its acquisition—

(1) sold or transferred to any entity (A) which would not have been qualified to file an application under section 222 of such Act (as such section was in effect prior to October 1, 1981) or (B) which is disapproved as a transferee by the State mental health agency or by another entity designated by the chief executive officer of the State, or

(2) ceases to be used by a community mental health center in the provision of comprehensive mental health services,

the United States shall be entitled to recover from the transferor, transferee, or owner of the facility, the base amount prescribed by subsection (c)(1) plus the interest (if any) prescribed by subsection (c)(2).

(b) The transferor and transferee of a facility that is sold or transferred as described in subsection (a)(1), or the owner of a facility the use of which changes as described in subsection (a)(2), shall provide the Secretary written notice of such sale, transfer, or change within 10 days after the date on which such sale, transfer, or cessation of use occurs or within 30 days after the date of enactment of this subsection, whichever is later.

(c)(1) The base amount that the United States is entitled to recover under subsection (a) is the amount bearing the same ratio to the then value (as determined by the agreement of the parties or in an action brought in the district court of the United States for the district in which the facility is situated) of so much of the facility as constituted an approved project or projects as the amount of the Federal participation bore to the cost of the remodeling, construction, expansion, or acquisition of the project or projects.

(2)(A) The interest that the United States is entitled to recover under subsection (a) is the interest for the period (if any) described in subparagraph (B) at a rate (determined by the Secretary) based on the average of the bond equivalent rates of ninety-one-day Treasury bills auctioned during that period.

---

[1] Relates to Indian hospitals and health facilities, 42 U.S.C. 2001 et seq.

(B) The period referred to in subparagraph (A) is the period beginning—

(i) if notice is provided as prescribed by subsection (b), 191 days after the date on which such sale, transfer, or cessation of use occurs, or

(ii) if notice is not provided as prescribed by subsection (b), 11 days after such sale, transfer, or cessation of use occurs,

and ending on the date the amount the United States is entitled to recover is collected.

(d) The Secretary may waive the recovery rights of the United States under subsection (a)(2) with respect to a facility (under such conditions as the Secretary may establish by regulation) if the Secretary determines that there is good cause for waiving such rights.

(e) The right of recovery of the United States under subsection (a) shall not, prior to judgment, constitute a lien on any facility.

USE OF FISCAL AGENTS

Sec. **[**2316**]** *2416*. (a) The Secretary may enter into contracts with fiscal agents—

(1)(A) to determine the amounts payable to persons who, on behalf of the Indian Health Service, furnish health services to eligible Indians,

(B) to determine the amounts payable to persons who, on behalf of the Public Health Service, furnish health services to individuals pursuant to section 319 or 322,

(2) to receive, disburse, and account for funds in making payments described in paragraph (1),

(3) to make such audits of records as may be necessary to assure that these payments are proper, and

(4) to perform such additional functions as may be necessary to carry out the functions described in paragraphs (1) through (3).

(b)(1) Contracts under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes (41 U.S.C. 5) or any other provision of law requiring competition.

(2) No such contract shall be entered into with an entity unless the Secretary finds that the entity will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(c) A contract under subsection (a) may provide for advances of funds to enable entities to make payments under the contract.

(d) Subsections (d) and (e) of section 1842 of the Social Security Act shall apply to contracts with entities under subsection (a) in the same manner as they apply to contracts with carriers under that section.

(e) In this section, the term "fiscal agent" means a carrier described in section 1842(f)(1) of the Social Security Act and includes, with respect to contracts under subsection (a)(1)(A), an Indian tribe or tribal organization acting under contract with the Secretary under the Indian Self-Determination Act (Public Law 93-638).

FAIR LABOR STANDARDS ACT

(29 U.S.C. 201–217)

AN ACT To provide for the establishment of fair labor standards in employments in and affecting interstate commerce, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, [That this Act may be cited as the "Fair Labor Standards Act of 1938".]

TITLE I—WAGES AND HOURS

SECTION 1. This Act may be cited as the "Fair Labor Standards Act of 1938".

SHORT TITLE

FINDING AND DECLARATION OF POLICY

SEC. 2. (a) The Congress hereby finds that the existence, in industries engaged in commerce or in the production of goods for commerce, of labor conditions detrimental to the maintenance of the minimum standard of living necessary for health, efficiency, and general well-being of workers (1) causes commerce and the channels and instrumentalities of commerce to be used to spread and perpetuate such labor conditions among the workers of the several States; (2) burdens commerce and the free flow of goods in commerce; (3) constitutes an unfair method of competition in commerce; (4) leads to labor disputes burdening and obstructing commerce and the free flow of goods in commerce; and (5) interferes with the orderly and fair marketing of goods in commerce.

(b) It is hereby declared to be the policy of this [Act] *title,* through the exercise by Congress of its power to regulate commerce among the several States, to correct and as rapidly as practicable to eliminate the conditions above referred to in such industries without substantially curtailing employment or earning power.

DEFINITIONS

SEC. 3. As used in this [Act] *title*—

* * * * * * *

ADMINISTRATOR

SEC. 4. (a) There is hereby created in the Department of Labor a Wage and Hour Division which shall be under the direction of an Administrator, to be known as the Administrator of the Wage and Hour Division (in this [Act] *title* referred to as the "Administrator"). The Administrator shall be appointed by the President, by and with the advice and consent of the Senate, and shall receive compensation at the rate of $10,000 a year.

(b) The Administrator may, subject to the civil service laws, appoint such employees as he deems necessary to carry out his functions and duties under this [Act] *title* and shall fix their compensation in accordance with the Classification Act of 1923, as amended. The Administrator may establish and utilize such regional, local, or other agencies, and utilize such voluntary and uncompensated services, as may from time to time be needed. Attorneys appointed under this section may appear for and represent the Administrator in any litigation, but all such litigation shall be subject to the direction and control of the Attorney General. In the appointment, selection, classification, and promotion of officers and employees of the Administrator, no political test or qualification shall be permitted or given consideration, but all such appointments and promotions shall be given and made on the basis of merit and efficiency.

(c) The principal office of the Administrator shall be in the District of Columbia, but he or his duly authorized representative may exercise any or all of his powers in any place.

(d) The Administrator shall submit annually in January a report to the Congress covering his activities for the preceding year and including such information, data, and recommendations for further legislation in connection with the matters covered by this [Act] *title* as he may find advisable.

* * * * * * *

MINIMUM WAGES

SEC. 6. (a) * * *

(b) This section shall take effect upon the expiration of one hundred and twenty days from the date of enactment of this [Act] *title.*

MAXIMUM HOURS

SEC. 7. (a)–(c) * * *

(d) This section shall take effect upon the expiration of one hundred and twenty days from the date of enactment of this [Act] *title.*

WAGE ORDERS

SEC. 8. (a) With a view to carrying out the policy of this [Act] *title* by reaching, as rapidly as is economically feasible without substantially curtailing employment, the objective of a universal minimum wage of 40 cents an hour in each industry engaged in commerce or in the production of goods for commerce, the Administrator shall from time to time convene the industry committee for each such industry, and the industry committee shall from time to time recommend the minimum rate or rates of wages to be paid under section 6 by employers engaged in commerce or in the production of goods for commerce in such industry or classification therein.

(b) Upon the convening of an industry committee, the Administrator shall refer to it the question of the minimum wage rate or rates to be fixed for such industry. The industry committee shall investigate conditions in the industry and the committee, or any authorized subcommittee thereof, may hear such witnesses and receive such evidence as may be necessary or appropriate to enable the committee to perform its duties and functions under this [Act] *title*. The committee shall recommend to the Administrator the highest minimum wage rates for the industry which it determines, having due regard to economic and competitive conditions, will not substantially curtail employment in the industry.

* * * * * * *

ATTENDANCE OF WITNESSES

SEC. 9. For the purpose of any hearing or investigation provided for in this [Act] *title* the provisions of sections 9 and 10 (relating to the attendance of witnesses and the production of books, papers, and documents) of the Federal Trade Commission Act of September 16, 1914, as amended (U.S.C., 1934 edition, title 15, secs. 49 and 50), are hereby made applicable to the jurisdiction, powers, and duties of the Administrator, the Chief of the Children's Bureau, and the industry committees.

* * * * * * *

INVESTIGATIONS, INSPECTIONS, AND RECORDS

SEC. 11. (a) The Administrator or his designated representatives may investigate and gather data regarding the wages, hours, and other conditions and practices of employment in any industry subject to this [Act] *title*, and may enter and inspect such places and such records (and make such transcriptions thereof), question such employees, and investigate such facts, conditions, practices, or matters as he may deem necessary or appropriate to determine whether any person has violated any provision of this [Act] *title*, or which may aid in the enforcement of the provisions of this [Act] *title*. Except as provided in section 12 and in subsection (b) of this section, the Administrator shall utilize the bureaus and divisions of the Department of Labor for all the investigations and inspections necessary under this section. Except as provided in section 12, the Administrator shall bring all actions under section 17 to restrain violations of this [Act] *title*.

(b) With the consent and cooperation of State agencies charged with the administration of State labor laws, the Administrator and the Chief of the Children's Bureau may, for the purpose of carrying out their respective functions and duties under this [Act] *title*, utilize the services of State and local agencies and their employees and, notwithstanding any other provision of law, may reimburse such State and local agencies and their employees for services rendered for such purposes.

(c) Every employer subject to any provision of this [Act] *title* or of any order issued under this [Act] *title* shall make, keep, and preserve such records of the persons employed by him and of the wages, hours, and other conditions and practices of employment maintained by him, and shall preserve such records for such periods of time, and shall make such reports therefrom to the Administrator as he shall prescribe by regulation or order as necessary or appropriate for the enforcement of the provisions of this [Act] *title* or the regulations or orders thereunder.

CHILD LABOR PROVISIONS

SEC. 12. (a) After the expiration of one hundred and twenty days from the date of enactment of this [Act] *title*, no producer, manufacturer, or dealer shall ship or deliver for shipment in commerce any goods produced in an establishment situated in the United States in or about which within thirty days prior to the removal of such goods therefrom any oppressive child labor has been employed: *Provided,* That a prosecution and conviction of a defendant for the shipment or delivery for shipment of any goods under the conditions herein prohibited shall be a bar to any further prosecution against the same defendant for shipments or deliveries for shipment of any such goods before the beginning of said prosecution.

(b) The Chief of the Children's Bureau in the Department of Labor, or any of his authorized representatives, shall make all investigations and inspections under section 11 (a) with respect to the employment of minors, and, subject to the direction and control of the Attorney General, shall bring all actions under section 17 to enjoin any act or practice which is unlawful by reason of the existence of oppressive child labor, and shall administer all other provisions of this [Act] *title* relating to oppressive child labor.

* * * * * * *

PROHIBITED ACTS

SEC. 15. (a) After the expiration of one hundred and twenty days from the date of enactment of this [Act] *title*, it shall be unlawful for any person—

(1) to transport, offer for transportation, ship, deliver, or sell, in commerce, or to ship, deliver, or sell with knowledge that shipment or delivery or sale thereof in commerce is intended, any goods in the production of which any employee was employed in violation of section 6 or section 7, or in violation of any regulation or order of the Administrator issued under section 14; except that no provision of this [Act] *title* shall impose any liability upon any common carrier for the transportation in commerce in the regular course of its business of any goods not produced by such common carrier, and no provision of this [Act] *title* shall excuse any common carrier from its obligation to accept any goods from transportation;

(2) to violate any of the provisions of section 6 or section 7, or any of the provisions of any regulation or order of the Administrator issued under section 14;

(3) to discharge or in any other manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this [Act] *title*, or has testified or is about to testify in any such proceeding, or has served or is about to serve on an industry committee.

* * * * * * *

PENALTIES

SEC. 16. (a) Any person who willfully violates any of the provisions of section 15 shall upon conviction thereof be subject to a fine of not more than $10,000, or to imprisonment for not more than six months, or both. No person shall be imprisoned under this subsection except for an offense committed after the conviction of such person for a prior offense under this subsection.

(b) Any employer who violates the provisions of section 6 or section 7 of this [Act] *title* shall be liable to the employee or employees affected in the amount of their unpaid minimum wages, or their unpaid overtime compensation, as the case may be, and in additional equal amount as liquidated damages. Action to recover such liability may be maintained in any court of competent jurisdiction by any one or more employees for and in behalf of himself or themselves and other employees similarly situated, or such employee or employees may designate an agent or representative to maintain such action for and in behalf of all employees similarly situated. The court in such action shall, in addition to any judgment awarded to the plaintiff or plaintiffs, allow a reasonable attorney's fee to be paid by the defendant, and costs of the action.

* * * * * * *

RELATION TO OTHER LAWS

SEC. 18. No provision of this [Act] *title* or of any order thereunder shall excuse noncompliance with any Federal or State law or municipal ordinance establishing a minimum wage higher than the minimum wage established under this [Act] *title* or a maximum workweek lower than the maximum workweek established under this [Act] *title*, and no provision of this [Act] *title* relating to the employment of child labor shall justify noncompliance with any Federal or State law or municipal ordinance establishing a higher standard than the standard established under this [Act] *title*. No provision of this [Act] *title* shall justify any employer in reducing a wage paid by him which is in excess of the applicable minimum wage under this [Act] *title*, or justify any employer in increasing hours of employment maintained by him which are shorter than the maximum hours applicable under this [Act] *title*.

SEPARABILITY OF PROVISIONS

SEC. 19. If any provision of this [Act] *title* or the application of such provision to any person or circumstance is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

TITLE II—MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

HEALTH BENEFITS

SEC. 201. (a) IN GENERAL.—Each employer shall, in accordance with title III of the Minimum Health Benefits for All Workers Act of 1988, enroll each of its employees and their families in a health benefit plan.

(b) ENFORCEMENT.—Any employer that does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Minimum Health Benefits for All Workers Act of 1988.

(c) DEFINITIONS.—The terms used in this section have the meanings prescribed for the terms by section 303 of such Act.

EMPLOYEE RETIREMENT INCOME SECURITY ACT

(29 U.S.C. 1001-1461)

Subchapter I—Protection of Employee Benefit Rights

Subtitle A—General Provisions

* * * * * * *

§ 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions). *Such terms include a health benefit plan established in accordance with title III of the Minimum Health Benefits for All Workers Act of 1988.*

* * * * * * *

Subtitle B—Regulatory Provisions

* * * * * * *

PART 5—ADMINISTRATION AND ENFORCEMENT

* * * * * * *

§ 1144. Other laws

(a) SUPERSEDURE; EFFECTIVE DATE.—Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) CONSTRUCTION AND APPLICATION.—(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in [subparagraph (B)] *subparagraphs (B) and (C),* nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

"(C) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, contracts or policies of insurance issued to or under a health benefit plan under title III of the Minimum Health Benefits for All Workers Act of 1988, except that a State may require an insurer, other than a regional insurer, to provide such evidence of financial stability as the State determines appropriate in order to be allowed to market insurance in the State.

* * * * * * *

○